INFLUENZA (BILLABLE CHILDREN AND ADULTS)

I have received and read the Vaccine Information Statement (VIS) about the influenza and influenza vaccine and I have had a chance to ask questions. I understand the benefits and risks of this vaccination and request that the vaccine be given to me or the person named below for whom I am authorized to sign. I furthermore release Warren County Public Health Nursing Agency and any other organizational site associated with influenza vaccine administration from any and all liability arising from this treatment (8/07/15).

PLEASE PRINT!

Name _____ **Gender: ____ Male ____ Female**

Date of Birth:_____ **Age:**_____ **Phone #**: _____

Street Address_____ **Medicare #:** _____

(Only Part B and NOT an HMO)

City _____ **State**_____ **Zip**_____

Warren County Resident _____Y/N

_____

SIGN NAME (Person receiving vaccine or Parent or Guardian)

PRINT NAME _____

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Warren County Public Health Nursing Agency any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the CMS (formerly known as Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services."

FOR CLINIC USE ONLY

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Clinic Site: _____
Date:_____ Injection Site:_____
Administered by: _____
Manufacturer: _____
Lot #: _____
Expiration: _____
Screening Questionnaire Reviewed: _____

VIS TAKEN_____ **VIS REFUSED**_____