Office Use Only
CA/CK

Immunization Clinic Information
Drive-Thru Flu Permission Form

Thank you for attending the Weber-Morgan Health Department Flu Drive-Thru Clinic. For your safety and the safety of others, please remain in your car and follow signs and those directing traffic. It is recommended that everyone over the age of 6 months receive an annual influenza vaccine to prevent illness and hospitalizations.

- **Please read the vaccine information statements provided or found at** www.webermorganhealth.org. They will answer questions you may have regarding these vaccines.
- **Please fill out both sides of this form.**

Weber Morgan Health Department can bill the following insurance companies if your child is covered by them:

- Aetna/Altius
- Blue Cross Blue Shield* (*Except Focal Point)
- CHIP
- Deseret Mutual
- Educators Mutual
- GEHA
- Medicaid
- PEHP
- Samera Health* (*T&C Network Only)
- Select Health
- TRICARE* (*May need referral from PCP)
- UMR
- United Health Care* (*Except Railroad Employees)
- University of Utah

Please choose one of the following payment categories:

☐ **I/my child has Medicaid or CHIP**. *(All information must be completed in order for us to bill)*

HMO/ACO Name: ___________________ Policy/Member ID#:_________________________________

☐ **I/my child has one or more of the insurances listed above:**
(All information must be completed in order for us to bill your insurance)

#1 Insurance Name: _________________________ Policy #:_______________ Group #:______________
Policy Holder Name: _____________________________ Policy Holder Date of Birth: ______________

#2 Insurance Name: _________________________ Policy #:_______________ Group #:______________
Policy Holder Name: _____________________________ Policy Holder Date of Birth: ______________

☐ **I/my insurance company is not listed above:** Influenza $30, High Dose Flu $70, Pnuemovax23 $131, Prevnar13 $230, Tdap $56

☐ **I/my child has insurance, but it does not cover vaccinations.**

Adults (Age 19+): Influenza $30, High Dose Flu $60, Pnuemovax23 $131, Prevnar13 $230, Tdap $56

Children (6 mo. to 18 years): Influenza $30, Tdap $56

☐ **I/my child does not have insurance:**

Adults (Age 19+): Influenza $30, High Dose Flu $70, *Pneumovax23 $131, Prevnar13 $230, Tdap $20
*Pneumovax for Adults 60+: $20

Children (6 mo. to 18 years): Influenza $20, Tdap $20

Cash or check is acceptable. Please make check payable to “WMHD”.
**If payment is indicated, it needs to be paid on the day of the clinic.*

If you would like us to send you an itemized receipt to submit to your insurance – please call (801)399-7250.

WEBER-MORGAN HEALTH DEPARTMENT
Drive-Thru Flu Permission Form

Please fill out the following information for the person receiving the vaccine.

Legal Name: ______________________________ Date of Birth: ____________ Age: ________

Address: _________________________________ City: _______________ ZIP Code: _________

Telephone #: ____________________________ Cell Phone #: __________________________

Race: _________ Ethnicity: ________ Sex: _____ Maiden Name (if applicable): ________________

I have been given a copy and have read, or had explained to me, the information contained in the Vaccine Information Statement for the person receiving the vaccine(s). I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) be given to me or the person for whom I am authorized to make this request. I agree that this information may be shared with schools, daycare centers, healthcare providers and others when medically necessary. I understand that it is my responsibility to know what my insurance plan covers and agree to pay the portion not covered by my insurance. I understand that if Weber-Morgan Health Department does not have a contract with my insurance company, or my insurance company denies payment, I am responsible for all charges incurred. I am hereby notified that the Weber-Morgan Health Department's Notice of Privacy Practices is located on their web site at www.webermorganhealth.org and I have had a chance to ask questions about how my public health information will be used.

Has the person receiving the vaccine:

1. been ill in the last week with anything more severe than a cold? ☐ No ☐ Yes
2. had a serious reaction to a previous vaccination? ☐ No ☐ Yes
3. been paralyzed by Guillain-Barre Syndrome? ☐ No ☐ Yes
4. had a serious allergy to any foods or medications? ☐ No ☐ Yes

   If yes, please list: ______________________________

5. had a seizure, brain, or nerve problem? ☐ No ☐ Yes

Requested Vaccine (s):

- Influenza Injectable ☐
- High Dose Flu Injectable (65+ Only) ☐
- Pneumovax 23 ☐
- Prevnar 13 ☐
- Tdap ☐

Signature: ____

*** Space below for Office Use Only***

The Stock Used is: VFC ☐ **Weber** ☐ **Special Project** ☐

Vaccine(s) Given:

☐ Flu _________________________ 0.5 cc
☐ High Dose Flu __________________ 0.5 cc
☐ Pneumovax23 __________________ 0.5 cc
☐ Prevnar13 _____________________ 0.5 cc
☐ Tdap _________________________ 0.5 cc

Site:

☐ L ☐ R Del/Thigh
☐ L ☐ R Del
☐ L ☐ R Del
☐ L ☐ R Del
☐ L ☐ R Del

Date: ______________

Nurse's Initials: _______

Notes:

____

____