| Office Use Only<br><br>CA/CK |
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# Flu Immunization Clinic Information

## *Drive-thru Form*

Vaccine Information Statements

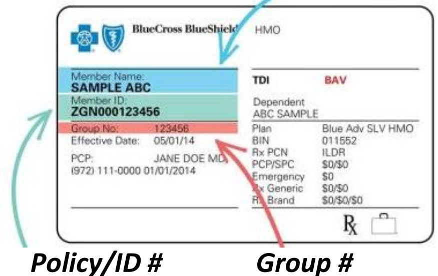
*Thank you for attending the Weber-Morgan Health Department Flu Drive-Thru Clinic. For your safety and the safety of others, please remain in your car and follow signs and those directing traffic. It is recommended that everyone over the age of 6 months receive an annual influenza vaccine to prevent illness and hospitalizations. Tdap and Pneumococcal vaccines will also be offered to adults. It is recommended that everyone receive a Tdap or Td booster every 10 years. Pneumococcal vaccines are recommended for all adults age 65 and older, and for some individuals younger than 65 with certain medical conditions.*

- **Fill out both sides of this form.**
- **Please read the Vaccine Information Statements,** which can be accessed by scanning the QR code above.

WMHD can bill the following insurance companies; however, we recommend that you verify that your insurance plan is in network with WMHD. Primary Care Physician referrals may be required.

- Aetna
- BlueCross BlueShield
- CHIP
- Deseret Mutual
- Educators Mutual
- GEHA
- Health Choice
- HealthEZ
- Medicaid
- Medicare
- Molina
- PEHP
- Samera Health
- SelectHealth
- TRICARE
- UMR
- United Health Care
- University of Utah

***Subscriber/Policy Holder Name***




**Please choose one of the following payment categories** *(ALL information must be completed in order for us to bill)*
*If you have more than one insurance, check **ALL** that apply. PLEASE ATTACH A COPY OF YOUR INSURANCE CARD.*

☐ 1) **The patient one or more of the insurances listed above*** *(Please list Medicaid or Medicare on options 2 or 3)* ***(W)***
Primary Insurance:________________________________ Policy #:________________ Group #:_____________
Subscriber Name:_________________________________ Subscriber Date of Birth: _______________________
Secondary Insurance: ______________________________ Policy #:________________ Group #:_____________
Subscriber Name:__________________________________ Subscriber Date of Birth: ______________________

☐ 2) **I/my child has*: ☐ Medicaid -or- ☐ CHIP** ***(0-18 VFC) (19+ W)***
*Check one:* ☐ Traditional Medicaid ☐ Health Choice ☐ Molina ☐ SelectHealth ☐ University of Utah
Member ID/Medicaid #:______________________ CHIP Policy # *(SelectHealth Only)*: ___________________

☐ 3) **I/my child has*: ☐ Medicare (Part B) -or- ☐ Medicare Advantage Plan** ***(W)***
Medicare #:____________________________
Insurance Name:________________________ Policy #: _________________ Payer ID #: __________________
Medical Claims Address: __________________________ City/State/Zip Code: ___________________________

☐ 4) **I/my child has NO insurance**.** ***(0-18 VFC) (19+ SP or W)***
Adults (age 19+): Flu Shot $20, Flu Mist $40, Flucelvax $45, Flublok $83, High Dose Flu $83, Tdap $20, Prevnar20 $20
Children (age 0-18): Flu Shot $20, Flu Mist $20

☐ 5) **I/my child has insurance that pays for immunizations but it is NOT listed on this form.**** ***(W)***
Adults & Children: Flu Shot $40, Flu Mist $40, Flucelvax $45, Flublok $83, High Dose Flu $83, Tdap $57, Prevnar 20 $262

☐ 6) **I/my child has insurance, but it does NOT cover vaccinations.**** ***(W)***
Adults & Children: Flu Shot $40, Flu Mist $40, Flucelvax $45, Flublok $83, High Dose Flu $83, Tdap $57, Prevnar 20 $262

***If payment is indicated, it needs to be paid on the day of the clinic.***

**Cash or check is acceptable. Please make check payable to "WMHD".**

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 Clinic Consent Form***

| Patient's name: | Date of Birth: | Age: |
|---|---|---|

| Phone: | Email: | SSN: |
|---|---|---|

| Address: | City: | Zip Code: |
|---|---|---|

| Gender *(circle one)*: **Female Male** | Race: | Ethnicity *(circle one)*: **Hispanic Non-Hispanic** | Mother's Maiden Name: |
|---|---|---|---|

| **The person receiving the vaccine:** | **YES** | **NO** |
|---|---|---|
| 1. has been ill in the last week with anything more severe than a cold? | ☐ | ☐ |
| 2. has a serious allergy to any foods or medications? *If yes, please list:* ______________________________ | ☐ | ☐ |
| 3. has had a serious reaction to a previous vaccination? | ☐ | ☐ |
| 4. has a history of Guillain-Barre Syndrome or had a seizure, brain or nerve problem? *If yes, please circle.* | ☐ | ☐ |
| 5. has taken antiviral medication in the last 2 weeks? | ☐ | ☐ |
| 6. has had a vaccine in the last month? *If yes, please list vaccine(s) & date:* ____________________________ | ☐ | ☐ |
| 7. is receiving aspirin therapy or medication that suppresses immune system (e.g. chemotherapy)? | ☐ | ☐ |
| 8. is pregnant, or has a chronic illness such as heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g. diabetes), a spinal fluid (CSF) leak, an immunocompromising condition, missing or non-functioning spleen or a cochlear implant? *If yes, please circle and describe:* ________________________________________________________________ | ☐ | ☐ |

**I would like to receive the Flu vaccine today.** YES ☐ NO ☐ **Preference:** Shot ☐ Mist ☐

**I would like to receive the Tdap vaccine today.** YES ☐ NO ☐

**I would like to receive the Prevnar 20 vaccine today.** YES ☐ NO ☐

*I 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 & risks of the vaccine(s) & 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 & others when medically necessary. I understand that it is my responsibility to know what my insurance plan covers & 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 & Patient Responsibility Form are located at [www.webermorganhealth.org](http://www.webermorganhealth.org) & I have had a chance to ask questions. Vaccine Information Statements can be accessed by scanning the QR code on the opposite side of this form & I have had an opportunity to review these & ask questions.*

**Patient/Parent/Guardian Signature:** ________________________________________________________________

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

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

| **Vaccine Given:** | | | | **Site:** |
|---|---|---|---|---|
| ☐ **FluMist** (2-49 yrs) ______________________ | 0.2ml | | Nasal |
| ☐ **Flu Shot** ( ≥ 6 mos) ____________________ | 0.5ml | ☐ PFS ☐ MDV | ☐ L ☐ R Del/Thigh |
| ☐ **Flucelvax** (≥ 6 mos)____________________ | 0.5ml | | ☐ L ☐ R Del/Thigh |
| ☐ **Flublok** (18 +) _________________________ | 0.5ml | | ☐ L ☐ R Del/Thigh |
| ☐ **HD Flu** (65 +) __________________________ | 0.7ml | | ☐ L ☐ R Del/ Thigh |
| ☐ **Tdap** _________________________________ | 0.5ml | | ☐ L ☐ R Del/Thigh |
| ☐ **Prevnar 20** ____________________________ | 0.5ml | | ☐ L ☐ R Del/Thigh |

Nurse's Initials _________________

**Notes:**______________________________________________________________________________

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