

Tulsa Health Department Seasonal Influenza and Pneumococcal Data Entry Form

I have read or had explained to me the information contained in the Influenza & Pneumococcal Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) be given to me or to the person for whom I am authorized to make the request. I have reviewed the Notice of Health Information Practices (HIPAA) and understand that immunization and billing information may be provided to school/child care officials, public health officials, health care professionals and insurance processing entities.

Last Name		First Name		Middle Initial	Date of Birth		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Street Address				City		State		Zip
Phone Number ()		Social Security		Ethnicity Hispanic Origin: Yes <input type="checkbox"/> No <input type="checkbox"/>		Race: White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/>		
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			Education Level:		
Medicaid/SoonerCare Number		Medicaid Last Name		Medicaid First Name		Mother's Maiden Name <i>(Required for Minors)</i>		
Do you have Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Medicare Primary? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare Number		<input type="checkbox"/> I have insurance. Name of insurance: _____ <input type="checkbox"/> My policy pays for flu shots. <input type="checkbox"/> I do not have Insurance.		
If you do not have medical insurance and wish to be considered for free flu shots, please provide the following information:				Gross Household Income: Please indicate the amount that most closely describes your total annual income: \$ _____		Number of people supported by this Income: _____		
<input type="checkbox"/> I choose not to report my income. I understand that I will be charged for my flu shot.				Permission to contact: <input type="checkbox"/> Yes <input type="checkbox"/> No		Signature of patient or parent/guardian X _____		
Office Use	VFC Status: <input type="checkbox"/> 1-Medicaid <input type="checkbox"/> 2-Native American <input type="checkbox"/> 3-Native Alaskan <input type="checkbox"/> 4-Underinsured <input type="checkbox"/> 5-No Insurance <input type="checkbox"/> 6-Private Insurance							
Payment Source:		<input type="checkbox"/> No Charge <input type="checkbox"/> Cash \$ _____		<input type="checkbox"/> Check # _____		<input type="checkbox"/> Health Choice <input type="checkbox"/> Vendor _____		<input type="checkbox"/> Community Care ID# _____
				Group # _____		Clerk _____		

Medical Screening Questions

Have you ever had a pneumonia shot? Yes No

Answer this screening question if child is 8yrs of age or under.

Has your child ever received a flu shot? Yes No

How many doses of the Influenza vaccine did your child receive last year? 0 1 2

Screening Questions for Live Nasal Influenza Vaccine

(For patient's age 2-49yrs requesting nasal mist)

1. Are you pregnant? Yes No
2. Is the patient a child or adolescent on long-term aspirin treatment? Yes No
3. Have you had one or more episodes of wheezing in the past year? Yes No
4. Do you have long term health problems with heart, lung, kidney, etc.? Yes No
5. Is the patient between 2 and 4 yrs of age and has wheezing or asthma? Yes No
6. Do you have allergic reaction to egg, arginine, gentamicin and/or gelatin? Yes No
7. Are you currently taking antiviral medication or have taken in the last 48 hours? Yes No
8. Do you have a weakened immune system or have close contact with anyone who does? Yes No
9. Has the person to be vaccinated received any other vaccinations in the past 4 weeks? Yes No

Screening Questions for Inactivated Flu Vaccine

1. Have you ever had a reaction to the influenza vaccine? Yes No
2. Do you have a fever, infection or current illness today? Yes No
3. Do you have an allergic reaction to chicken eggs, latex, thimerosal or gelatin? Yes No
4. Have you ever experienced Guillain-Barre syndrome (severe paralytic illness)? Yes No

For Office Use Only – Do Not Write Below this Line

Vaccine Type	Date	Lot Number	Site	Signature / Initials	Vaccine Type	Date	Lot Number	Site	Signature / Initials
FLUMIST – VFC					FLUMIST				
FLUVIRIN 4-18y – VFC					FLUVIRIN 4y & up				
FLUZONE 6m-18y – VFC					FLUZONE 6m & up				
FLUZONE 3-18y – VFC					FLUZONE 3y & up				
FLUZONE 6-35M					FLUZONE 65y & up				
FLUZONE ID					FLUARIX 3y & up				
FLUARIX 3-18y - VFC					FLULAVAL 18y & up				
FLUAFLURIA 9-18y – VFC									
					PNEUMOVAX				
Site / Route: 1 = RVL / IM 2 = LVL / IM 3 = RD / IM 4 = LD / IM 9 = Other / Nasal Intradermal: 12 = RT Deltoid Region ID 13 = LT Deltoid Region ID									