Cozad Community Health System – School Influenza Vaccination & Admission Form

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI:** _____
Date of Birth: ____ / ____ / _____ **Age:** _____ **Sex at Birth:** ☐ M ☐ F
Social Security #: _____ **Mother's Maiden Name:**_____
Address: _____**P.O. Box (if applicable):** _____
City: _____ **State:** _____ **Zip:** _____
Phone: (_____) _____ **Email:** _____
Primary Language_____ **Height**_____ **Weight**_____

☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

INSURANCE INFORMATION

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____
Insurance Provider: ☐ Blue Cross Blue Shield ☐ United HealthCare ☐ Medicaid (circle one: UHC / NTC / Molina) ☐ Medicare ☐ No Insurance ☐ Other: _____
Subscriber Name (if different): _____
Subscriber Date of Birth: ____ / ____ / _____ **Subscriber SS#:** _____
Member ID #: _____ **Group ID #:** _____
Employer: _____
☐ Copy of insurance card (front & back) attached

ADMISSION DETAILS

If Patient is a Minor (under 19):
Responsible Party: _____
Date of Birth: ____ / ____ / _____ SSN: _____
Relationship to Patient: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Employer: _____

Please complete the back of this page as well.

SCREENING QUESTIONS

(Must be completed before vaccine is administered)

1. Do you have allergies to eggs or a vaccine component? ☐ Yes ☐ No ☐ Unknown
2. Have you ever had difficulty breathing after receiving a vaccination? ☐ Yes ☐ No ☐ Unknown
3. Have you ever had a seizure, brain/nervous system disorder, or Guillain-Barré? ☐ Yes ☐ No ☐ Unknown

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CONSENT AND AUTHORIZATION

I give consent to the Cozad Community Health System and its staff to vaccinate the person listed above. I have read or had explained to me the Emergency Use Authorization or Vaccine Information Statement and understand the risks and benefits.
I grant permission for CCHS to release any necessary information to my insurance company or any referring physician. I understand that CCHS and its affiliates are not liable for any actions or omissions of staff, volunteers, or partnering agencies involved in vaccination.

Parent/Guardian Signature: _____ **Date:** ____ / ____ / _____

THIS SECTION STAFF USE ONLY

VACCINE ADMINISTRATION

Vaccine	Manufacturer	Lot/Exp	Dose	Site (circle)	Nurse/Date
FluLaval	GSK		0.5ml	LA / RA	
Flublok	Sanofi		0.5 ml	LA / RA	
Fluzone	Sanofi		0.5 ml	LA / RA	
Fluzone HD	Sanofi		0.5 ml	LA / RA	

Temperature: _____

NESIIS: _____ / _____ **Billed:** _____ / _____ ☐ Paid Cash/Donation

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