Public Health
Prevent. Promote. Protect.
Coffey County Health Department

Drive– Thru Flu Shots

Coffey County Health Department Presents:

Seasonal Influenza Vaccine

Friday September 28th Burlington 10:00am-1:00pm

Coffey County Hospital EMS Bay

Evening Clinics Available 5:30-6:30 Fire Stations

Wednesday September 26th– LeRoy

Wednesday October 3rd– New Strawn

Wednesday October 10th– Waverly

Monday October 15th– Lebo

Wednesday October 17th– Gridley

Monday October 22nd– Burlington

$30.00 for injection —6 months and older

*High Dose $60.00– **Only** available for 65 years and older*

or present current insurance card

(we accept BCBS/Medicare/Kancare)

Consent on back

MEDICATION TAKE BACK– Bring any expired, unused medications no questions

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Influenza Consent Form

Last Name _____First Name_____ MI_____

Street Address/ PO Box_____

City_____State_____County_____Zip_____

Male_____ Female_____ Date of Birth_____ Phone#_____

Age_____ Personal Physician _____

Please answer the following questions and information below

Have you ever had a flu shot before?----------yes ____ no ____
Do you have a cold, fever, or acute illness?----------yes ____ no ____
Are you allergic to chicken eggs or egg products?----------yes ____ no ____
Have you ever had an allergic reaction to flu vaccine or Pneumococcal vaccine?— yes ____ no ____
Have you been diagnosed with Guillain-Barre Syndrome?----------yes ____ no ____
If you are 65 or older would you like the High Dose vaccine?——————-yes____ no____

I hereby certify that the foregoing history is true and complete to the best of my knowledge and request and authorize receipt of the influenza vaccine. I verify that I have been offered a copy of the Vaccine Information Statement. I hereby authorize CCHD to release any information necessary to file a claim for payment to my insurance company. I acknowledge that I have reviewed a copy of CCHD's Notice of Privacy Practices with the effective date of April 14, 2003. I have been offered a copy of the Vaccine Information Statement. I have read, had explained to me and understand the information in the vis. I consent to inclusions of the immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below. VIS Date 08/2015

Patient Signature_____Date_____

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Cardholder Name_____ ID#_____
(*Exactly as it appears on card)*

Payment Method:

Cash/Check BCBS Medicare KanCare Other_____

Pre-Filled 6-35 months Sanofi-Pasteur	Route LVL RVL	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications
Pre– Filled 36-Older Sanofi Pasteur	Route LD RD LVL RVL	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications
MDV (Multi Dose Vial) Sanofi Pasteur	Route LD RD	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications
FluBlok 50-64 yrs Sanofi Pasteur	Route LD RD	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications
High Dose 65– Older Sanofi Pasteur	Route LD RD	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications
PCV13 (VIS 11/05/15) PPSV23(VIS04/24/2015	Route LD RD	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications