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

Drive– Thru
Flu Shots

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Coffey County Health Department Presents:
Seasonal Influenza Vaccine
5:30pm-6:30pm
Fire Stations

Consent on back -Please complete before arriving

Wednesday, September 27th– New Strawn
Wednesday, October 4th– Lebo
Monday, October 9th– Waverly
Wednesday, October 11th– LeRoy
Monday, October 16th-Gridley
Wednesday, October 18th -Burlington

Present current insurance card *or payment of:*

$45.00 for 6 months of age and older

$90.00 High Dose– ***Only*** *available for 65 years and older*

MEDICATION TAKE BACK–

Bring any expired, unused medications no questions asked

Coffey County Health Department
Influenza Consent Form

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PLEASE COMPLETE BEFORE ARRIVING

Last Name _____First Name_____ MI_____

Mailing Address_____

City_____State_____County_____Zip_____

Male_____ Female_____ Date of Birth_____ Phone #_____

Age_____

MUST PRESENT INSURANCE CARD

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

Cardholder Name_____ Cardholder's Date of Birth_____

Relationship to Cardholder Self Spouse Child Other_____

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 above. VIS Date 08/06/2021

Patient/Guardian Signature_____Date_____

☐ Picture of patient Insurance Card

Pre-Filled 6 months and older Sanofi-Pasteur	Route LVL RVL 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