HAMILTON COUNTY HEALTH DEPARTMENT
FLU AND PNEUMONIA VACCINATION RECORD

Patient's Name:	*(last)* *(first)* *(middle)*	
Date of Birth:		**Age:**
Street Address:		
City/State/ZIP:		
Phone:	*(home)* *(work)*	
Social Security:	*(Required for billing TennCare and Medicare)*	

Race: (check all that apply)	**Sex:**	**Marital Status:**	**Hispanic:**	**Primary Language:**
☐ White	☐ F	☐ Single	☐ Yes	☐ English
☐ Asian	☐ M	☐ Married	☐ No	☐ Spanish
☐ Black		☐ Divorced		☐ Other
☐ Native Am		☐ Separated		
☐ Pacific Is		☐ Widowed		
☐ Other				

USA Born? ☐ Yes ☐ No If no: Entry Date to U.S:____________Country of Origin: ____________________

ACKNOWLEDGEMENT AND AUTHORIZATION: By my signature below, I acknowledge the following:

- I have received a copy of Hamilton County Health Department's Notice of Privacy Practices.
- I have read the information contained in the "Important Information" form(s) about the disease(s) and the vaccine(s) to be administered.
- I have had a chance to ask questions which were answered to my satisfaction.
- I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on the back of this form be given to me or to the person named as the patient for whom I am authorized to make this request.
- I authorize payment of medical benefits (if any) on my behalf to the Hamilton County Health Department and authorize the release of any medical or other information necessary to process this claim.

SIGNED:____**DATE:** ________________

(Patient or Authorized Person's Signature)

DO NOT WRITE BELOW THIS LINE

S (Medicare Part B) **5BAD (Blue Advantage)** **5RRM (Railroad Medicare)** **5022 (Blue Cross)** **5XM5 (Cover Kids)**	**ID #:** ________ **Group#:**______ **Effective Date:** __	**Verified in Computer** ☐ **Or** **Copy of Card Attached** ☐
6 Private Pay	**Previous Balance:** ______________ **+ Today's Charge:** _ **- Amt. Paid:** ______________ **= New Balance:**	**Manual Receipt Number:**_____________ **Or** **Attach a copy**
A (TennCare)	**(Circle One)** **ABCS ATCH ATAG ATCS** **APBCS APTCS ABTCS**	**TennCare #:** **Effective Date:** **(Attach copy of card)**
Private Insurance	**Yes No (circle one)**	

Patient Name :____ D.O.B: ____________________

To Be Completed By Nurse

Allergies to food, medicine, latex, eggs or thimerosal? (**Please reference Vaccine Components Table for specific product**)

☐ Yes ☐ No **If yes**, to what?:

Serious reaction to a vaccine in the past? ☐ Yes ☐ No **If yes**, what vaccine(s):

	Health Conditions:
☐ yes ☐ no	Seizures or history of seizures or active neurological condition
☐ yes ☐ no	History of Guillain-Barré Syndrome *(Refer to PCP)*
☐ yes ☐ no	Been told by a doctor not to have an intramuscular injection
☐ yes ☐ no	Bleeding disorder *(Dr. order required – verbal or written)*
☐ yes ☐ no	Current Acute Febrile Illness
☐ yes ☐ no	Other Medical:____________________
	Medications/Immunizations:
☐ yes ☐ no	History of Pneumonia Vaccine *(please refer to Immunization Protocols for Pneumovax (PPSV23) Prevnar (PCV13, PCV20) for guidance* **PCV13**______ **PCV20**______ **PPSV23**______
☐ yes ☐ no	Other Recent Immunization:____________________
☐ yes ☐ no	Other Medications: ____________________
	Education:
☐ yes ☐ no	Fever Management/injection site discomfort
☐ yes ☐ no	Instructed to wait 20 minutes post vaccine administration
☐ yes ☐ no	Booster Dose education, if applicable below age 9
☐ yes ☐ no	Flu and Flu Mist VIS Form: 08/06/2021
☐ yes ☐ no	Pneumovax (PPSV23) VIS Form: 10/30/19
☐ yes ☐ no	Prevnar (PCV13) VIS Form: 02/04/22
☐ yes ☐ no	Prevnar (PCV20) VIS Form: 02/04/22
☐ yes ☐ no	Td VIS Form: 08/06/21 or Tdap VIS Form: 08/06/21
☐ yes ☐ no	Other Education Provided:____________________

Procedure Code	Prog Code	Reim	Provider	Mfg	Lot Number	Route IM	Dose
Federally Qualified (Uninsured) Adults						Inj Site	
90686 Fluarix (19-64) (PFS)	AH	6		GSK		RA LA	0.5 ml
90674 Flucelvax (19-64) (PFS)				SEQ		RA LA	0.5 ml
	AH	TennCare				RA LA	0.5 ml
VFC Children	CH	Medicare					
90686 Flulaval/Fluzone (6 mos –18 yrs–PFS)	(thru			GSK			0.5 ml
90688 Fluzone (6 mos – 18 yrs – MDV)	20)	Blue Adv		SPI			0.5 ml
90674 Flucelvax (6 mos – 18 yrs-PFS)				SEQ			0.5 ml
90672 FluMist (2 yrs – 18 yrs)		RRM					
Privately-Insured Children + Adults		BlueCross					
90682 Flublok (18 yrs +)				SPI		RA LA	0.5 ml
90686 Fluarix (6 mos +)- adult		CoverKids		GSK		RA LA	0.5 ml
90662 Hi-dose Fluzone(65+ yrs)				SPI		RA LA	0.7 ml
*Vaccine admin - 6 mos –18 yrs **90460**							
*Vaccine admin – 19+ yrs **90471**							
*Vaccine admin – Medicare **G0008**							
90715 (Tdap) / 90714 (Td)				SPI/GSK		RA LA	0.5 ml
90732 (Pneumovax)				MSD		RA LA	0.5 ml
90670 (Prevnar-PCV13)				PFR		RA LA	0.5 ml
90677 (Prevnar-PCV20)				PFR		RA LA	0.5 ml

Comments: ____

____

PROVIDER SIGNATURE:______________________________ **DATE:** ________________