REGISTRATION AND CONSENT FOR SERVICES
COMMUNITY HEALTH AND PREVENTION SERVICES
DEKALB COUNTY BOARD OF HEALTH

INFORMATION ON PERSON TO RECEIVE SERVICES **(PLEASE PRINT)**

Last Name	**First Name**	**Middle Initial**	**Birthdate**	**Age**

Address	**Apt No.**	**City**	**County**	**State**	**Zip code**

Phone#: ____ **Home:** ____ **Work:** ____ **Other:** ____	**Race:** ______ Black (B) ______ Hispanic White (Z) ______ American Indian (I) ______ White (W) ______ Hispanic Black (X) ______ Alaska Native (E) ______ Asian (A) ______ Multi-racial (M)	**Sex** _______Male _______Female

Marital Status: _____ Married (M) ______ Divorced (D) _____ Single (S) ______ Widowed(W)	**Insurance Carrier** **Member ID #** **Group #**	**Medicaid # / Medicare Part B# (circle one)**

I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Statement(s) for the vaccines checked below. I have had the opportunity to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines requested and ask that the vaccines checked be given to the person named for whom I am authorized to make the request. I authorize the release of this immunization record to other healthcare providers on request.

☐ Influenza ☐ Influenza Nasal ☐ Pneumococcal ☐ Td/Tdap ☐ Hepatitis A ☐ Hepatitis B ☐ HPV ☐ Meningococcal ☐ Hepatitis A/B combo ☐ TB Skin test

SIGNATURE OF PERSON AUTHORIZED TO MAKE REQUEST	**DATE OF SIGNATURE**

FOR OFFICE USE ONLY

Vaccine	State Eligible code (VFC)	State Eligible code (GIP)	Not Eligible	Site	VIS (Mo/Yr)	Route	Provider	MFG	Lot #	Fee
Influenza Vaccine (flozone- High dose) 65 yrs & older (Trivalent)	n/a	n/a	FLHD		8/7/2015	IM				$65.00
Influenza Vaccine (flublok- High dose) 65 yrs & older (Quadrivalent)	FLBK	n/a	FLBX		8/7/2015	IM				$21.93/$65.00
Influenza Vaccine (fluzone 1 dose vail) 36mos & older Sanofi (Quadrivalent)	FLVV	n/a	FLUZ		8/7/2015	IM				$21.93/$35
Influenza Vaccine (fluzone) vial 6 mos - 35 mos Sanofi (Quadrivalent)	FLC	n/a	FLM		8/7/2015	IM				$21.93/$35
Influenza Vaccine (fluzone) no preserv 6 mos to 35 mos (Quadrivalent)	FLCF	n/a	n/a		8/7/2015	IM				$21.93/$35
Influenza Vaccine (fluarix) no presv 36mos & older GSK (Quadrivalent)	FLUX	n/a	FL4		8/7/2015	IM				$21.93/$35
Influenza Vaccine (fluzone) 6mos & infinity	FLQ	n/a	FLU		8/7/2015	IM				$21.93/$35
Influenza Vaccine (fluvirin) vial 4 yrs and up	FLV	n/a	FLVA		8/7/2015	IM				$21.93/$35
Influenza Vaccine (flulaval) 6 mos & infinity, GSK (Quadrivalent)	FLUV	n/a	FLUL		8/7/2015	IM				$21.93/$35
Influenza Vaccine (flucelvax) 4-18 years older, Seqires (Quadrivalent)	FLCV	n/a	n/a		8/7/2015	IM				$21.93
Influenza Vaccine (fluzone syring) 36 mos & older, Sanofi (Quadrivalent)	FLW	n/a	FLWZ		8/7/2015	IM				$21.93/$35
Pneumo 13 (PCV)	PNU	PCXG	PCX		11/5/2015	IM				$21.93/$177
Penumo 23 (PPSV)	n/a	PNV	PNE		04/24/15	IM				$21.93/$114
MMR	MMR	MMA	MMX		4/20/12	SC				$21.93/$83
Varicella	VZV	VZA	VZX		3/13/2008	SC				$21.93/$144
Hep A > 19	n/a	HAH	HAA		7/20/16	IM				$21.93/$65
Hep B > 19	n/a	HBA	HBV		7/20/16	IM				$21.93/$67
Hep A/B	n/a	AAB	ABH		7/20/16	IM				$21.93/$98
Menactra	MEN	n/a	MEX		7/20/16	IM				$21.93/$130
HPV	HPV	HPA	HPX		12/2/16	IM				$21.93/$160
Meningococcal	n/a	n/a	MCV		3/31/16	IM				$145.00
Meningococcal B (Beexsero)	BEXS	n/a	BEXX		3/31/16	IM				$21.93/$185
Meningococcal B (Trumenba)	TRUM	MEE	TRUX		3/31/16	IM				$21.93/$134
Menveo	MEV	n/a	MNV		3/31/16	IM				$21.93/$130
TDAP	TDP	TPA	TDT		2/24/15	IM				$21.93/$55
Kinrix (DTap/IVP)	KNRX	n/a	n/a		5/17/07-7/20/16	IM				$21.93
PPD Skin Test	n/a	n/a	PPD		X	SQ				$24.00
Medicare Flu Adm. Fee	n/a	n/a	AFL			X				26.15
Medicare PNE Fee	n/a	n/a	APN			X				26.15
Medicare HBV Adm. Fee	n/a	n/a	AHB			X				26.15
Administrative Fee --- SHBP	n/a	n/a	90471	X	X	X	X	X	X	$40.00
Administrative Fee --- SHBP	n/a	n/a	90472	X	X	X	X	X	X	$21.00
Administrative Fee --- SHBP	n/a	n/a	90474	X	X	X	X	X	X	$20.00

________________________ Nurses Signature

________________________ Date

Method of Payment
☐ Cash
☐ Check # ____________
☐ Credit Card
☐ Medicare ____________
☐ Blue Cross/Blue Shield

☐ Medicaid ____________
☐ Invoice ____________
☐ Cigna
☐ United Health Care
☐ Aetna
☐ Coventry

Amount Paid ____________________