



# Beat the Flu! On-Site Flu Shot Clinics

Healthstyles and Macomb County Health Department are sponsoring flu clinics for current Macomb County employees again this Fall. Vaccinations will be administered by staff from the Macomb County Health Department Immunization Program.

**Employees with Macomb County sponsored HAP, BCN, or BCBS PPO** — bring a copy of your insurance card (front *and* back) and drivers license to your appointment. If you have insurance offered through Macomb County the flu shot is **FREE**. Employees without Macomb County insurance can pay out of pocket for the flu shot—\$20 (cash or check only).

Make sure to sign up for your appointment—register at: <http://signup.com/go/bRexZfR>

**Vaccinations take less than 10 minutes!** Employee Walk-ins will be accepted.

\*Please note, the vaccine is administered in the upper arm, so wear short sleeves or clothing that allows for easy exposure of your upper arm/shoulder.



## CLINIC TIMES AND LOCATIONS

Tuesday, September 25th 11 AM—2 PM	Wednesday, September 26th 1 PM-3:45 PM	Thursday, September 27th 7 AM—830 AM	Thursday, September 27th 2 PM—4 PM	Wednesday, October 3rd 10 AM—2 PM
Verkuilen Building Conference & Training Center	Juvenile Justice Center Conference Room	MCHD Mount Clemens Clinic	Sheriff Office WEST ENTRANCE	Administration Building - 9th Floor

Email [Healthstyles@macombgov.org](mailto:Healthstyles@macombgov.org) with any questions

**PLEASE PRINT**

**ADULT FORM (19 and older) Office Use only: Client ID# \_\_\_\_\_**

**Macomb County Health Department Seasonal Influenza Vaccine Program Date: \_\_\_\_\_ Time: \_\_\_\_\_**

Birthdate: \_\_\_\_\_ Social Security # (last 4 digits) \_\_\_\_\_ Medicare #: \_\_\_\_\_

Legal Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ (Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ (Middle Name) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Telephone # \_\_\_\_\_ Sex (Circle One): Male Female

Are you enrolled in any of the following? (check all that apply) \_\_\_\_\_ Medicare Part B \_\_\_\_\_ Medicaid \_\_\_\_\_ No Medical Insurance

\_\_\_\_\_ Commercial Insurance that **does** cover immunizations (circle) BCBS OF MI BCN HAP MCLAREN PRIORITY OTHER \_\_\_\_\_

\_\_\_\_\_ Commercial Insurance that **does not** cover immunizations \_\_\_\_\_

**THIS SECTION TO BE COMPLETED ONLY BY VALID MEDICARE PART B CARD HOLDERS and/or COMMERCIAL INSURANCES ACCEPTED BY MACOMB COUNTY HEALTH DEPARTMENT:**

I authorize any holder of medical information about me to release to Medicare and/or my commercial insurance or their Intermediaries or carriers, information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment below.

**Signature X** \_\_\_\_\_ Macomb County Health Department Accepts Assignment

**Medical Screening Questionnaire and Consent for Vaccination**

Please **circle** the answer to the following questions about you or the person to be vaccinated:

- YES NO 1. Have you ever had a serious reaction to a vaccine?
- YES NO 2. Are you allergic to eggs, Thimerosal, gelatin, latex or any antibiotics?
- YES NO 3. Have you received an influenza vaccination before?
- YES NO 4. Have you ever had Guillain-Barré Syndrome (GBS)?
- YES NO 5. Do you have any long-term health problem such as heart or lung disease, kidney disease or metabolic disease (diabetes)?
- YES NO 6. Are you a current smoker?
- YES NO 7. Do you have severe thrombocytopenia (low platelet count) or a bleeding disorder?
- YES NO 8. Are you currently ill or running a fever?
- YES NO 9. Do you have asthma or have you had a recent episode of wheezing in the past 12 months?
- YES NO 10. Are you or do you think you may be pregnant?
- YES NO 11. Have you received any vaccine within the past 30 days?
- YES NO 12. Do you have cancer, leukemia, lymphoma, or any immune deficiency disease (inability to fight infection) or are you currently receiving chemotherapy, radiation therapy or steroid therapy (prednisone or cortisone)?
- YES NO 13. Do you have close contact with anyone who has a severely weakened immune system (for example, an individual who has had a bone marrow transplant and is currently in a hospital isolation room)?

(Use for Community Outreach Settings only)  
 Medical Screener:  
 \_\_\_\_\_ (initials/3 digit ID)  
 (Include MCHD Staff 3 digit ID)  
 Denied Reason:

I have read or have had explained to me, the information contained in the Vaccine Information Statement(s) regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Macomb County Health Department to release my immunization record information, or the immunization record information of the person for whom I am authorized to make this request to other health care provider(s) as needed.

**Macomb County Health Department Notice of Health Information Practices**

I have received a copy of Macomb County Health Department's Notice of Health Information Practices. I understand that my acknowledgement of the Notice is evidenced by my signature on this document. The Department is required to abide by the terms of this privacy notice. The Department may change the terms of its notice at any time. The new notice will be effective for all protected health information that it maintains at that time. Upon my request, the Department will provide me with the revised notice of privacy practices.

**X** \_\_\_\_\_  
SIGNATURE of Client/Legal Guardian

\_\_\_\_\_  
PRINT NAME of Legal Guardian (if applicable)

THIS SIDE OF FORM TO BE COMPLETED BY MACOMB COUNTY HEALTH DEPT STAFF ONLY

<b>MCHD OFFICE STAFF USE ONLY:</b>				<b>Date of Service:</b> _____	
____ Medicare	____ Self Pay	MC (01) _____	Client ID _____		
____ Medicaid	____ No Pay (Waived/250)	WRN (02) _____	SCS (03) _____	(91/92/93) Facility Zip Code _____	
Does client have ____ BCBS OF MICHIGAN ____ BCN ____ HAP ____ MCLAREN ____ PRIORITY ____ OTHER _____					

Nurse Staff ID \_\_\_\_\_

Nurse Confirmation of Client's Birthdate: \_\_\_\_\_

<u>Vaccine</u>	<u>Mfg/Lot#</u>	<u>Route</u>	<u>Site</u> (Circle One)	<u>VIS Date</u>	<u>VIS Given</u>
FLQ (IIV4)	_____	IM	RT LT RD LD	08/07/2015	_____
FLVQ (IIV4)	_____	IM	RT LT RD LD	08/07/2015	_____
FLHD (IIV3) CP (65 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/07/2015	_____
FLUA (aIIV3) CP (65 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/07/2015	_____
FLCX (ccIIV4) CP (4 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/07/2015	_____
FLBQ (RIV4) CP (18 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/07/2015	_____
PP23	_____	SC IM	RA LA RD LD	04/24/2015	_____
TDP	_____	IM	RT LT RD LD	02/24/2015	_____
Td	_____	IM	RT LT RD LD	02/24/2015	_____
PCV13	_____	IM	RT LT RD LD	11/5/2015	_____
Hep A	_____	IM	RT LT RD LD	7/20/2016	_____
_____	_____	IM	RT LT RD LD	_____	_____

Progress Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please copy Medicare Part B card or MEDICAID card/commercial insurance cards and driver's license below.  
(If Medicare Part A only, do not copy Medicare card; client becomes self pay client)