Mitchell County Health Department
310 W. 8th St Beloit, KS 67420
785-738-5175

INFLUENZA (FLU) IMMUNIZATION CONSENT FORM AND MEDICARE Billing CONSENT FORM

Name: _____
First, Middle, & Last (If Medicare Card, please print as name appears on card)

Street Address: _____ Home Phone:_____

City, State, and Zip Code: _____ Cell Phone: _____

Date of Birth: _____ Age: _____

Social Security: _____ Primary Doctor: _____

Insurance/Medicare Number: _____

Are you Pregnant? Yes☐ No☐

I have been given a copy and have read, or have had explained to me, the information in the "Vaccine Information Statement" (VIS) and ask that the flu vaccine be given to me or the person named for whom I am authorized to make this request. I authorize the release of any medical or other information necessary to process this claim. I request the payment of benefits to the Mitchell County Health Department.

I understand I am responsible for payment if this vaccination is not paid for by my insurance.

_____ _____
Signature required – Relationship to Client Date

OFFICE USE ONLY

Date of Injection_____Site: IM RD IM LD IM LVL IM RVL

Clinic Site: Hlth. Dept. CC GE Tipton Hunter

other_____

_____ MDV

_____ FluBlok

Nurse Signature & Title_____

_____ High Dose

_____ 0.5 ml Syringe