Franklin County Health Department

Public Health
Prevent. Promote. Protect.

September 23, 2024

Dear Parent/Guardian:

The Franklin County Health Department will be providing Influenza vaccinations at Franklin County Schools. This year, the vaccine will, again protect against both Seasonal Influenza and H1N1 flu. There will be no cost to the parents for this vaccination. However, we will be billing insurance companies.

To sign up for an appointment please visit: FCHD.org/SchoolFluVaccine. Please be sure to select an appointment date, based on the school where your child attends. If you need a paper form you may request one from your child's school. Please return it to your child's homeroom teacher; don't forget to answer the medical history questions and sign for consent. Parents/Guardians are not required to be present when their child receives the vaccination, if they have signed the consent form in advance.

We will only be administering injectable flu vaccine this year. You may access the Influenza Vaccine Information Sheet and the Notice of Privacy Policy mentioned on the form, on our website, at www.fchd.org, or you may request one from your child's school.

Your child will receive their flu vaccine in October 2024 if parent/guardian signs the consent form. You can go to our website, at www.fchd.org or contact your child's school to find the flu vaccine schedule.

Remember this year we need your insurance information but there will be no co-pays. If you have any questions or concerns, you may contact your school nurse.

Sincerely,

Michelle Searcy, RN

Michelle Searcy, BSN, RN
School Nurse Supervisor

Franklin County Health Department
Influenza Vaccine Year 2024-2025

PEF Label

Name: _____
First *Middle* *Last*

Address: _____ ☐☐ ☐☐☐☐☐
Street *City* *County* *State* *Zip Code*

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ **Email**: _____

SSN: ☐☐☐-☐☐-☐☐☐☐ **Birthdate: (MM-DD-YYYY)** ☐☐-☐☐-☐☐☐☐ **Age**: _____

Sex: ☐ Male ☐ Female **Ethnicity:** ☐ Non-Hispanic/Latino ☐ Hispanic/Latino
Race: ☐ White ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native
☐ Asian ☐ Multi-racial

chool-age child? ☐ *Yes* ☐ *No* *School*_____ *Homeroom Teacher*: _____

oes the patient have Medicaid?: Medicaid Number: _____ MCO Number: _____
] Yes ☐ No MCO (circle one): Aetna Anthem Humana Molina United Wellcare

oes the patient have Medicare?: Medicare Number: _____
] Yes ☐ No

oes the patient have Insurance?: Insurance Name: _____
] Yes ☐ No

Policy ID: _____ Group ID: _____

Yes	No	Medical History Questions
☐	☐	Has the patient had Guillan-Barré syndrome within 6 weeks following a previous flu vaccine?
☐	☐	Has the patient eaten eggs and had difficulty breathing (anaphylactic reaction)?
☐	☐	Has the patient had a fever in the past 24 hours?
☐	☐	Is the patient taking Theophylline or Warfarin (blood thinner)?
☐	☐	Is the patient allergic to any medicine or latex? _____

I have read or have had explained to me the information sheet: Influenza Vaccine, (Inactivated or Recombinant) what you need to know (VIS Dated 08/06/2021).

I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

I also understand that the patient may be tested for HIV, hepatitis B, or any other disease carried by blood or body fluids if such a test(s) is needed if a health care worker is exposed to the patient's blood, body fluids or tissue.

I request that payment of authorized medical insurance benefits be made to Franklin County Health Department on my behalf or behalf of my child, for services received. I also authorize the local health department to release medical information to Medicare, other third party payors (insurance carriers, Medicaid, etc.) and their agents to determine payment for services. I am aware that should Medicare refuse payment for this service, I will be responsible for the cost. If I am covered by a billable private insurance, I am aware that I may be responsible for some additional charges not covered by my plan.

The health department may keep this record in a medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's lot number, the vaccine injection site, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

I have received or been offered the HIPAA privacy notice (available online at FCHD.org).

X_____ DATE: _____
Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian/representative)

Revised 08.26.24

Franklin County Health Department
Influenza Vaccine Year 2024-2025

FOR HEALTH DEPARTMENT USE ONLY

Vaccine Manufacturer and Lot # _____

Injection Site ☐ Left Deltoid ☐ Right Deltoid
☐ Left Anterolateral Thigh Muscle ☐ Right Anterolateral Thigh Muscle

Provider Signature: _____ Provider Number: _____ Date: _____

✓ 80000 Unspecified Procedure **ICD-10:** Z23. Encounter for Immunization

✓	Influenza **(VFC, Adult Stimulus or MEDICAID)**		✓	Influenza **(NON-VFC, Private Insurance, Self-Pay, Medicare)**	
	90460	Admin of Influenza age 18 and below, **1** Unit		G0008	Admin of Flu Vaccine Private Insurance
	90471	Admin of Influenza age 19 and above		90656NV	IIV3 PF, 6 months & above (Fluzone or Fluarix)
	90656	IIV3, 6 months-18 yrs **VFC** (FluLaval)		90662	IIV3-HD, HIGH DOSE, age 65 yrs & above (Fluzone)
	90660	LAIV3, 2yrs-18 yrs **VFC** (FluMist)		90673NV	RIV3, AGE **18 yrs and older** (Flublok)
	90661	ccIIV3, 6 months -18 yrs **VFC** (Flucelvax)			
	90656FR	IIV3, 19 yrs and above – No Insurance (Afluria)			
	90656NV	IIV3 PF, 6 months & above (Fluzone or Fluarix)			

VFC ☐ Yes ☐ No
FFC ☐ Yes ☐ No

Flu Pricing: Trivalent-$35.00
High Dose-$85.00
Adult Stimulus-$5.00
V FC-Sliding scale based on income

☐ Cash ☐ Check # _____ ☐ Credit Card ○Visa ○Mastercard ○Other

Amount Paid: _____

Initials:_____

Revised 08.26.24