Adair County Health Department's Drive-Thru Flu Clinic

Please plan to attend our "Annual Drive-through Flu Clinic/Exercise to be held Thursday, October 1, 2015 from Noon – 6:00 PM at the NEMO Fair Grounds in Kirksville. The Clinic will be provided at No-Cost for Adair County Residents.

- **For Ages 4yrs and up**
- **Please complete your "Flu Assessment Screening and Consent Form" (see back page)**
- **Please wear clothing suitable to receive the flu vaccine in your arm.**
- **Please bring your Medicare or Medicaid card**
- **Questions? Please call 660-665-8491 or go to http://adair.lphamo.org**
- **Thanks for your participation in this important emergency preparedness exercise!**

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Flu Assessment Screening and Consent Form

Name:_____Date of Birth:_____Age:_____

Address:_____

City State Zip Code

Phone#:_____County:_____Sex:____Male___Female

Your Medicare Number_____ Your Medicaid Number_____

Do you have private insurance? Yes or No

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Please answer the following questions: (if answer yes, please explain)

1. Do you have a cold, cough, fever or chills? **Yes or No**_____
2. Are you **allergic** to eggs, chicken, or feathers? **Yes or No**_____
3. Have you received vaccines or injections in the last 4 weeks? **Yes or No**_____
4. Are you taking antibiotics or prednisone, cortisone, anti-cancer or other drugs that might prevent you from getting the vaccine? **Yes or No**_____
5. Have you had Influenza vaccine (flu) before? **Yes or No**_____
6. For Women: Are you pregnant? **Yes or No If yes, Have you checked with your doctor?_____**
7. Do you faint with injections? **Yes or No If yes,_____**
8. Do you have asthma or a chronic health condition? **Yes or No _____**

Please read the following statement

This record will be kept at the Adair County Health Department in a file. It will record when the vaccine was given, the name of the company that made the vaccine, the vaccine lot number and who and where the vaccine was given. I have read and or received a copy of the Vaccine Information Statement and I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine to be given.

I understand that if I have Medicare and/or Medicaid insurance, my insurance will be billed for the vaccine and injection. I acknowledge by my signature below, that I have been offered a copy of Adair Co. Health Department/Home Health Agency "Notice of Privacy Practice Act (HIPAA)", and have read the statement above.

_____ _____

Signature of Patient or Parent/Guardian **Date**

For clinic staff use only

_____Referred for further medical screening

_____Recommended for vaccine

_____No vaccine given

TYPE OF VACCINE:FLU/MANUFACTURE/LOT#EXPIRATION DATE;

Date Given:_____

Initials of person giving vaccine:_____(see signature/credentials, initials sign in sheet) **VFC**