WELCORE HEALTH VACCINE ADMINISTRATION RECORD (adult/child)

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Tax ID Number: 27– 5414185 NPI Number: 1760780126

INFORMATION ABOUT PERSON TO RECEIVE VACCINE.

Date of Service:	Amount Pd/billed

Client's Name (Last, First, Middle Initial):	Date of Birth:	Age:	Male	Female

Race:	Ethnicity:	Birth State/Country:	Telephone Number:

Address (Street or PO Box):	City:	County:	State:	Zip Code:

Name of Responsible Financial Party:	Address if different from Client's address:	Relationship to Client:

Primary Insurance Co (Medicare, BCBS):	Insurance Co Address, City, State, Zip:	Insurance Policy / Medicare #:	Group #(if applies) /Humana Gold Choice:

Policy Holder (first, last) Name:	Policy Holder Address, City, State, Zip:	Date of Birth:	Relationship to Client:

Secondary Insurance Co Name:	Insurance Co Address, City, State, Zip:	**Insurance Policy #:	Group # (if applies):

Policy Holder (first, last) Name:	Policy Holder Address, City, State, Zip:	Date of Birth:	Relationship to Client:

Authorization, acknowledgment, and assignment of insurance benefits (Please **INITIAL** all statements that apply)

_____ I authorize the release of any medical or other information necessary to process this claim.

_____ I acknowledge that WelCore Health has provided me with their Notice of Privacy Practices. I understand I may request a copy of the notice.

_____ If I am the client, or an individual legally obligated to pay for medical expenses provided to the client or a guarantor of payment, I assign and authorize any third party payer/insurer to make direct payment to WelCore Health of all benefits payable for the Client's care.

ADULTS 19 YEARS OF AGE AND OLDER MAY SKIP QUESTIONS 1-4 AND GO ON TO QUESTION 5.

Screening Questions: 1-4 are to determine whether your child qualifies for a federally funded immunization program titled vaccine for children.

□ Yes □ No 1. Is your child enrolled in Medicaid?
□ Yes □ No 2. Does your child have more than one private health insurance policy?
□ Yes □ No 3. Does your child's private health insurance cover vaccinations from WelCore Health? □ Unknown
□ Yes □ No 4. Is your child Native American or Alaskan Native?

Screening questions adult or child: Has the person to be vaccinated:

□ Yes □ No 5. had any problems after receiving previous vaccines?
□ Yes □ No 6. have any allergies to latex, food, medicine, or any vaccine? List _____
□ Yes □ No 7. have a brain problem, ever had a seizure or Guillain-Barre´ syndrome?
□ Yes □ No 8. have a serious long-term health problem such as heart, lung, liver, or kidney disease; diabetes, alcoholism, or cerebrospinal fluid leaks?
□ Yes □ No 9. have any problems with his/her immune system, such as cancer, leukemia, or HIV/AIDS?
□ Yes □ No 10. taken cortisone, prednisone, other steroids, anti-cancer drugs, or x-ray treatments in the past 3 months?
□ Yes □ No 11. been told you have asthma or wheezing?
□ Yes □ No 12. received any vaccines in the past four weeks?
□ Yes □ No 13. Is the person to be vaccinated on aspirin therapy?
□ Yes □ No 14. Is the person to be vaccinated sick today?
□ Yes □ No 15. Is the person to be vaccinated pregnant or think they may be pregnant?
□ Yes □ No □ Don't know **16. For persons 6 months to 8 years of age**: did your child receive 2 or more seasonal influenza vaccines since July 1, 2010?

Which form of the vaccine do you prefer? **Shot** **Mist (ages 2-49 years)** **(Please circle preference.)**

My signature below indicates:

I have read, or have had explained, the Vaccine Information Statement(s) about the vaccine(s) recommended and the disease(s) for which they provide protection. There was an opportunity to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) discussed and ask that those vaccine(s) be given to me or the person for whom I am authorized to make this request.

_____

Signature **Date**

Nursing Assessment:_____
Nurse's Initials **Date**

Vaccine To Be Given	Route	VIS Date	MGF (Circle)	Lot Number	S/P	Admin Site	Nurse's Initials	2nd Dose needed?
LAIV Seasonal Flumist- 2-49 yrs	IN	07/02/12	MED			NASAL		Y N
TIV Seasonal (influenza split) inactivated	IM	07/02/12	SP GSK			RD LD RT LT		Y N
Tdap	IM	01/24/12	GSK			RD LD		

Comments:_____ **DATE:**_____