Gila County
Health & Emergency Management
Prevent. Promote. Protect.

GILA COUNTY DIVISION of HEALTH and EMERGENCY MANAGEMENT
5515 South Apache Ave., Suite 100, Globe, AZ 85501
PHONE: (928) 402-8811 FAX: (928) 425-0794

ADULT FLU ADMINISTRATION RECORD AND CONSENT

PLEASE PRINT CLEARLY

FIRST Name Middle **LAST** Name _____

Age _____ Date of Birth Month Day Year _____

Mailing Address: _____

☐ Male ☐ Female

City: _____ Zip _____

Telephone Number: _____

Please answer the questions below by checking "YES" or "NO" in the box on the left:

YES	NO	
☐	☐	Do you have an allergy to eggs that causes a dangerous reaction?
☐	☐	Are you ill and have a fever today?
☐	☐	Have you had a serious reaction to a previous flu shot?
☐	☐	Have you had Guillain-Barre Syndrome? (a paralytic illness)

√(check) all that apply:
☐ Uninsured ☐ Native American ☐ AHCCCS* ☐ Have Private Health Insurance* ☐ Medicare B
*PRIMARY Health Plan Name_____ Member Name _____
MEMBER ID_____ Subscriber's SSN_____
*SECONDARY Health Plan Name_____ Member Name _____
MEMBER ID _____ Subscriber's SSN_____

MEDICARE B NUMBER _____

ASSIGNMENT OF BENEFITS: I hereby assign to Gila county Health Department any insurance of other third-party benefits available for health care services provided to me. I understand that Gila County Health Department has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Gila County Health Department, I agree to forward the County Health Department all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

I Agree to allow the health care provider giving vaccination to release information about all vaccinations given to me, or to the person for whom I am authorized to consent, to the Arizona State Immunization information System (ASIIS), other healthcare providers and the schools in order to avoid receiving unnecessary vaccinations and to provide information in order to receive the vaccination I request.

I have read or have had explained to me the information contained in the Vaccine Information Material (08/15/2019) about the disease and the vaccine. I have the right to ask questions that will be answered to my satisfaction. I understand the benefits and risks of flu shots and authorize the Gila County Office of Health to administer the influenza vaccine to me or the person named below for whom I am authorized to make this request.

Signature: _____ Date:_____

Printed Name: _____ Date: _____

Name_____ Date of Birth_____

INSURANCE / PAID **MEDICARE** **VFA**

INJECTION SITE

LD RD

LVL RVL

RN – Screener/Administrators Signature _____ Date: _____