HARRISON COUNTY
Home & Public Health
Department

Adult Influenza/Pneumonia Vaccination Form

Courthouse Annex
116 N. Second Ave.
Logan, IA 51546
Ph: (712) 644-2220

Amount Paid: _____

Cash or Check #: _____

Make checks payable to HCHPH

PLEASE PRINT

Last Name _____ First Name _____ Middle _____ Maiden _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Other Phone#: _____

Birth Date: _____/_____/_____ Male _____ Female _____
Month Date Year

Physician's Name: _____ Address: _____

Have you ever had a serious reaction to eggs or any component of the influenza vaccine? Yes_____ No _____
Are you sick today? Yes_____ No _____
Have you ever had Guillain Barré syndrome? Yes_____ No _____

I have read the vaccine information sheet, or have had the information explained to me. I have had a chance to ask questions and I understand the benefits and risks of the vaccine and ask that the vaccine be given to me. I accept responsibility for seeking medical attention for any reactions to the vaccination. CDC-VIS 08/07/2015 _____(Initial)

I certify that I have read a copy of the Harrison County Home & Public Health Privacy Notice. I also understand that if I do not have Medicare B coverage, or if I am enrolled in a Medicare HMO plan, I will be responsible to pay the full amount associated with my vaccination.

Signature: _____ **Date:** _____

Please Print: _____

PLEASE SHOW MEDICARE CARD TO NURSE

Medicare Number with the ***alphabet letter after number:*** _____

NURSES ONLY

Flu vaccine - Site: RD/LD Lot # _____

Pneumonia - Site: RD/LD Lot # _____

Administered by: _____ Entered Into IRIS: _____