## SESSIT LAKE COUNTY HEALTH DEPARTMENT

## **School Encounter Form**

## No charge Flu Vaccine

## Please check one:

Private Insurance: Injection Only (Flu Mist not available due to grant limitations)

🗆 Medicaid 🗆 Non-Insured 🗆 CHIP 🗀 American Indian/Alaska Native

### Parental preference: Flu Mist Injection

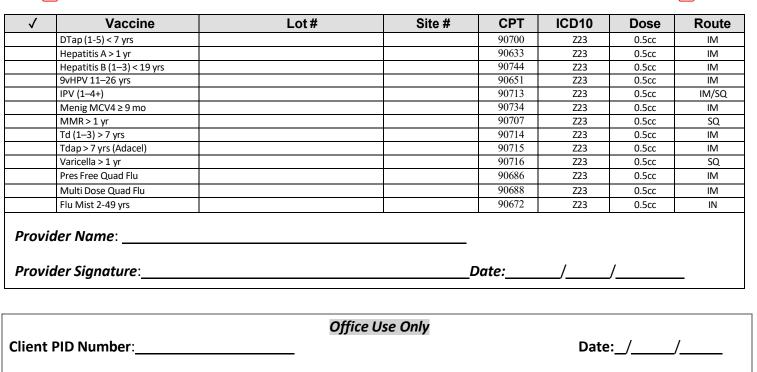
There are a limited number of Flu Mist administrations.

### Yes $\Box$ No $\Box$ If Flu mist is unavailable, my student may receive an injection.

First Name:			Last Name:	Last Name:			Middle Nai	me:
Date of Birth:		Sex: Male 🗌	Female	Rac	ce:		Ethnicity:	Hispanic or Latino 🗌 Not Hispanic or Latino 🗌
Address:					Apartm	nent:	City:	
State:	Zip Code:	Home Phon				Cell Phone		
Parent's Name:								

- 1. Are you well today? Y or N
- 2. Have you had any immunization in the last month? Y or N Type:\_
- 3. Any problems with previous vaccines/fainting? Y or N
- 4. Have you had blood products in the past 6-11 months? Y or N
- 5. Are you on aspirin therapy? Y or N
- 6. Any problems with your immune system? Y or N
- 7. Female more than 9 yrs of age? Could you be pregnant? Y or N
- 8. Have you had history of chicken pox? Y or N

## STOP! SCHOOL USE ONLY BELOW



Registered: Employee Name\_\_\_\_\_

Close Out: Employee Signature



# **Conditions of Treatment**

### Please read and initial each item below:

### **Consent for Treatment**

I have received a copy and have read, or had explained to me, the information contained in the Vaccine Information Statement(s) about the vaccine(s) I have requested or have been recommended to me, their risks, and about the disease(s) that the vaccine(s) protect against. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated in the Vaccine Information Statement(s) stated above be given to me or to the person for whom I am authorized to make this request. I certify that these statements are true and accurate.

### Insurance Coverage

Applies only if billing Medicaid, Medicare, and/or a Salt Lake County Health Department-contracted insurance

I understand that my health insurance coverage may have certain restrictions and limitations. I agree to pay the full amount for any and all related charges, if they are not covered by my insurance. If I fail to pay for these services and charges within sixty (60) days of receiving notice that the charges are not covered for any reason, my account will be turned over to collections. In the event my account is turned over to collections, I agree to pay attorney fees and collection charges which may apply. I hereby request and authorize the Salt Lake County Health Department to submit claims to my Medicaid. Medicare and/or Health Department-contracted insurance.

### **Privacy Rights**

I have been provided and have had the opportunity to read Salt Lake County Health Department's Notice of Privacy Practices. Furthermore, any questions I had regarding the policy have been explained to me by the Health Department staff. In addition, I understand that I may request a copy of these practices in a reasonable alternative format. I agree that this information may be shared with health care providers, health care personnel, public health personnel and other health care professionals who have a legitimate need to access the immunization information to: verify immunization status; audits; conduct public health studies; and assist a patient or to protect the health of individuals closely associated with the patient. I understand that I have the right to revoke this authorization at any time by notifying the Salt Lake County Health Department in writing. This release of information will be effective until canceled in writing. I understand that once my data is shared with another individual or agency, it may lose the protections provided by the HIPAA Privacy Rule, and may be re-disclosed by that recipient.

### Indicate relationship to the person receiving services:

Self Parent	Sibling (over 18)	Grandparent	
Guardian	Other:		
If under 18 years of age:			
l am a:			
Pregnant Minor	Married Minor	Homeless Teen	
By signing, you indicate that you have copy of this document; and that you a authorized to sign this agreement and	re the patient, guarantor, th		
Patient Name (please print): _			
Your Name (please print):			
Signature:		Date:	

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