Drive-Thru Flu Vaccine Clinics

Get Your Flu Shot Here

Topaz Ranch Estates	Indian Hills Senior Center	Douglas County Community Center	Kahle Community Center
10/05/2021	**10/06/2021**	**10/13/2021**	**10/15/2021**
10am-12pm	10am-1pm	9am-12pm	11am-2pm

Please wear a mask regardless of vaccination status. All ages are welcomed. Limited vaccine availability. First come, first serve basis.

We will bill Nevada Medicaid, Medicare, and most private insurances.

Please bring all of your insurance cards. Insured patients are responsible for confirming their flu vaccination coverage with their insurance company,

For uninsured or underinsured, the flu shot is $20.

For more information about our events, please call (775) 782-9038

Douglas County Community Health Immunization Questionnaire

PLEASE PRINT NAME & ANSWER QUESTIONS FOR PERSON GETTING VACCINATED: Maiden Name: ____________________

Patient Name: ____________________ Phone (____)____________________

Street Address ____________________ Unit/Apt#: ________ City/State/Zip Code____________________

Birth Date ____/____/____ (Month Day Year) Age Today ________ Gender ☐ F ☐ M History of Chicken Pox ☐ Yes ☐ No

Race (Check one box only)	**Ethnicity** (Check one box only)	**Social Security Number #**
☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander	☐ Hispanic/Latino ☐ Not Hispanic/Latino	_____-_____-_____ Required to access immunization records online
Emergency Contact Name: ____________________	**Emergency Contact Phone #:** ____________	**Emergency Contact Relation:** ____________

Insurance Status

☐ **Medicare #:** ____________________ *If you have supplemental plan & Medicare, please include under "Primary Insurance"	☐ **Uninsured / No insurance** ☐ **Insured, but vaccines are not a covered benefit**
☐ **Medicaid #:** ____________________ *If you have private insurance & Medicaid, please include under "Primary Insurance"	☐ **NV Check-Up #:** ____________________

☐ **Primary Insurance Company** ____________________ **Member ID:** ____________________

Policy Holder Name: ____________________ Birth Date: ___/___/___ Relationship to Patient: ____________

Street Address(*if different from patient*) ____________________ Unit/Apt# _____ City/State/Zip Code ____________

ATTENTION: It is advised to wait approximately 15 minutes after receiving a vaccination before driving.

Question		
1. Are you sick today?	☐ YES	☐ NO
2. Have you been exposed to any sick person (with or without COVID) in the past 14 days? **If yes, when:** ____________	☐ YES	☐ NO
3. Do you have allergies to eggs, latex, food, medication, vaccine ingredients? **If yes, list:** ____________	☐ YES	☐ NO
4. Had a serious reaction to or fainted with previous immunization?	☐ YES	☐ NO
5. Had Guillain-Barre syndrome in the past?	☐ YES	☐ NO
6. Had seizure or other nervous system problem?	☐ YES	☐ NO
7. Have cancer, AIDS or other immune system problems?	☐ YES	☐ NO
8. Taken cortisone, prednisone or any steroids, anti-cancer drugs, or radiation in the last 3 months?	☐ YES	☐ NO
9. Received antiviral drugs in the last 3 months?	☐ YES	☐ NO
10. Do you use tobacco products?	☐ YES	☐ NO
11. Received any other immunizations, including influenza, in the last month? **If yes, list:** ____________	☐ YES	☐ NO
12. Received a blood or blood product transfusion, or been given immune (gamma) globulin in the last year?	☐ YES	☐ NO
13. Have long-term medical problems: diabetes, heart, kidney or lung disease, asthma, wheezing or blood disorders?	☐ YES	☐ NO
14. Pregnant or plan to become pregnant in the next month?	☐ YES	☐ NO
15. Been vaccinated against influenza (flu) in the past?	☐ YES	☐ NO

The foregoing information is true and correct to the best of my knowledge. I have read, or have had read to me, and I understand the vaccine information sheets for the immunizations(s) to be administered. I have had an opportunity to ask questions, and any questions were answered to my satisfaction and I understand the benefits and risks of the vaccine(s). I consent to (or give consent on behalf of my dependent for) the administration of the vaccine. I authorize the release of any medical or other information with respect to this vaccine to Medicare, Medicaid or other third party payer as needed and request payment of authorized benefits to be made on my behalf (or on behalf of my dependents) to Douglas County Community Health (DCCH). I acknowledge that my vaccination record may be shared with federal or state agencies for registry reporting, including the Nevada Immunization Registry. I acknowledge receipt of the DCCH Notice of Privacy. I certify my receipt of services covered by this claim. I fully release and discharge DCCH and its agents from any liability for illness, injury, loss or damage which may result from the administration of the vaccine(s).

Client/Parent/Legal Guardian Signature ____________________ Date ____/____/______

Client/Parent/Legal Guardian **Print Name** ____________________

Parent or Legal Guardian Can Sign Only. Signature required if person to be vaccinated under 18 years of age.

-- For Office Use Below --

Influenza Quadrivalent, PF	PVT	VFC	317			RD	LD	IM

Event: ____________ **Date:** ____________	**Amt. Paid:** $________ Initials ________ ☐ Cash ☐ Check ☐ CC ☐ NP	**eCW/Scan Init** _____	**RN eCW Init** _____	**Revised 9/2021 DA Approved**