2025-26 FLU VACCINATION FORM

NAME:_____ DATE OF BIRTH:_____ RACE:_____ SEX:_____

PHONE #:_____ SOC. SEC#:_____ HISPANIC: ☐ YES ☐ NO

ADDRESS: _____

MOTHER'S MAIDEN NAME (LAST, FIRST)_____ ☐ INSURED ☐ NONINSURED

MEDICARE #:_____ MEDICAID #:_____

PVT INSURANCE NAME_____ POLICY # _____GROUP/ID#_____

CLAIM MAILING ADDRESS_____

NAME OF CARD HOLDER IF NOT SAME AS PATIENT_____

DOB OF CARD HOLDER _____RELATIONSHIP TO PATIENT_____

COMPANY BILL_____

ALLERGIES TO ANY VACCINES_____

PROVIDERS USE ONLY:

Influenza Vaccine Mfgr./Lot#_____ Site: ☐Right/☐Left ☐Deltoid/☐Thigh Date:_____ Administered by:_____

Other Vaccine Mfgr./Lot#_____ Site: ☐Right/☐Left ☐Deltoid/☐Thigh Date:_____ Administered by:_____

Other Vaccine Mfgr./Lot#_____ Site: ☐Right/☐Left ☐Deltoid/☐Thigh Date:_____ Administered by:_____

_____ Initials **STATEMENT OF UNDERSTANDING**: I have read and understand the information provided to me about receiving vaccines and I have had the opportunity to ask questions.

_____ Initials I give my voluntary consent for Albemarle Regional Health Services to use and disclose health/medical information for purposes of treatment, payment, and health care operations. I request that payment of benefits be made to Albemarle Regional Health Services with the understanding that any unpaid balance from co-pays, deductibles, and/or non-covered charges will be my responsibility. I understand that the health/medical information used and disclosed may include information about communicable diseases (such as HIV). I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. I understand that this consent is valid until I revoke it and that if I want to revoke this consent, I must do so in writing.

_____ Initials I hereby acknowledge that I may request a copy of the "Notice of Privacy Practices" for Albemarle Regional Health Services and understand that I may contact the person named therein if I have questions about the content of the Notice.

_____ _____

Signature of patient, parent, legal guardian, or other legally responsible person (when required) Date

_____ _____

Signature of Witness Date

CPT CODE	NDC #		TRADE NAME	S/P	DOSE	AGE RANGE
90660	Flumist	66019-0112-10	Flumist	S	0.2 mL Intranasal	2 years – 49 years
90656	Fluzone	49281-0425-50	Fluzone	S	0.5mL (single-dose syringe)	6 months & older
90656	Flulaval	49281-0425-50	Flulaval	S	0.5mL (single-dose syringe)	6 months & older
09656	Afluria	33332-0025-03	Afluria	S	0.5mL (single-dose syringe)	3yr and older
90653	Fluad Trivalent High-Dose	70461-0025-03	FLUAD	P	0.5 mL (single-dose syringe)	65 years & older
90656	Fluzone	49281-0425-50	Fluzone	P	0.5mL (single-dose syringe)	6 months & older

	90471	Injection – x's 1 unit	**G0008**	FLU Injection for *Medicare*
	90472	Injection – 2 or more UNITS____	**G0009**	Pneumonia injection for *Medicare*