OAKLAND COUNTY MICHIGAN
HEALTH DIVISION
OAKGOV.COM/HEALTH

OAKLAND COUNTY HEALTH DIVISION
CORONAVIRUS / INFLUENZA VACCINE

REV 09/2024

LEGAL NAME: Last	First	Birth Date: Month-Day-Year
		_____ – _____ – _____
Street Address		**AGE:**

City	State	Zip	Telephone

Race: ☐ Asian ☐ Middle-Eastern ☐ Black/African American ☐ Native American/Alaskan ☐ Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other ☐ More than one race/ethnicity

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic/Latino

Sex assigned at birth: ☐ Female ☐ Male
Gender identity: _____
Pronouns: _____

ALL CLIENTS:

1. Is the person to be vaccinated sick today? ☐ Yes ☐ No
2. Does the person to be vaccinated have an allergy to a component of the vaccine? ☐ Yes ☐ No
3. Has the person to be vaccinated ever had a serious reaction to any vaccine or injectable therapy in the past? ☐ Yes ☐ No

COVID VACCINE:

1. Does the person to be vaccinated have moderate to severe immune compromise due to a medical condition or medication? ☐ Yes ☐ No
2. Has the person to be vaccinated ever developed myocarditis or pericarditis after an mRNA vaccine? ☐ Yes ☐ No

INFLUENZA VACCINE:

1. Has the person to be vaccinated ever had Guillain-Barre Syndrome? ☐ Yes ☐ No
2. Is the person to be vaccinated a solid organ transplant recipient age 18-64 receiving immunosuppressive medication? ☐ Yes ☐ No

I have been given a copy and have read, or have had explained to me, the information contained on the vaccine information sheets about the diseases and vaccines which are to be administered today. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the specific vaccines and I ask that the vaccines I have requested be given to me, or to the person named above for whom I am authorized to make this request, and understand that administration of the vaccines will be recorded in the Oakland County Health Division Electronic Medical Record and in the Michigan Care Improvement Registry.

I have received a copy of Oakland County's Notice of Privacy Practices, describing the County's use or disclosure of my protected health information (or the protected health information of a person for whom I have authority to authorize medical treatment), for the purpose of diagnosing or providing treatment and care for me or such person, obtaining payment or reimbursement for any health care bills for which I or such person are responsible, and to conduct its health care operations. I understand that my acknowledgement of this Notice is evidenced by my signature on this document.

CONSENT FOR MINOR: ☐ **IN-PERSON** ☐ **VERBAL**

Client/Parent/Guardian signature: ➔_____ **Date:** _____

Parent/Guardian printed name: _____

● **COVID** ☐ **FFS** ☐ **VFC** (6mo-18 yrs)

☐ **MODERNA** (12 & older) FFS w/7.00 = $131

☐ **MODERNA** (6mo-11 yrs) FFS w/7.00 = $120

● **Lot #** _____

● **Body Site** LeftArm RightArm LThigh RThigh

● **FLU Vaccine** ☐ **FFS** ☐ **VFC** (6mo-18 yrs)

☐ **FLUAD (65+)** FFS w/7.00 = $63

☐ **FLULAVAL** ☐ **FLUZONE** FFS w/7.00 = $25

● **Lot #** _____

● **Body Site** LeftArm RightArm LThigh RThigh

● **PHN** _____

● **Vaccination Date** _____

● **OCHD CLINIC/EVENT** ☐ **NORTH** ☐ **SOUTH** ☐ ***OUTREACH**

Outreach location/event/homebound visit – please indicate:

* *Service provided at:* _____

FFS: ☐ **Cash/CC** ☐ **SS** ☐ **Employee Prog** ☐ **OakFit Prog**
☐ **Insurance, type:** _____
Policy #_____

VFC (6mo-18 yrs): ☐ **Medicaid- $0** ☐ **Underinsured- $7 only**
☐ **Uninsured- $7 only** ☐ **Native American- $7 only**

INITIALS: _____ **CASH: $**_____ **RECEIPT #**_____