WHAT: Flu Shot Clinic

WHERE: Heritage Center
  251 So. State Avenue
  Hampton, IL 61256

WHEN: October 1\textsuperscript{st} from 3:00p to 6:00p

Due to COVID they will not have forms for you to fill out! You have to bring them to the clinic along with your insurance or payment. If you do not have a printer I have copies printed out at Village Hall and will provide them for you here or email/call us if you cannot get here and we will mail you a set.

mreyes@hamptonil.org (309) 755-7165
ROCK ISLAND COUNTY HEALTH DEPARTMENT

UNITED HEALTH CARE
UMR
BLUE CROSS BLUE SHIELD (PPO PLAN)
MEDICAID
MERIDIAN
ILLNICARE
BLUE CROSS COMMUNITY HEALTH PLAN (MEDICAID)

MEDICARES
AETNA
COVENTRY
HUMANA
MEDICARE PART B
UNITED HEALTH CARE MEDICARE SOLUTIONS
UNITED HEALTH CARE AARP
UNITED HEALTH CARE MEDICARE COMPLETE

***PEOPLE WHO DO USE INSURANCE (EVEN THOUGH THEY ARE LISTED ABOVE) ARE RESPONSIBLE FOR FINDING OUT IF THEIR INSURANCE COVERS VACCINES AND CONFIRM THAT ROCK ISLAND COUNTY HEALTH DEPARTMENT IS WITHIN NETWORK.

NO HMO INSURANCES ARE ACCEPTED AT THIS HEALTH DEPARTMENT.

**STATE EMPLOYEE WORKERS ONLY** WE WILL BILL THE STATE DIRECTLY

IF NO INSURANCE THE FEE FOR REGULAR FLU IS $35 AND FOR HIGH DOSE IS $55
RICHDAULT FLU CONSENT

FULL NAME: ________________________________

First Name: ____________________________ M ____________________________ Last Name: ____________________________

DATE OF BIRTH: __________________________ AGE: __________________________

CIRCLE GENDER: MALE FEMALE

CITY: __________________________

STATE: __________________________ ZIP CODE: __________________________

CIRCLE RACE: WHITE BLACK/AFRICAN-AMERICAN ASIAN AMERICAN INDIAN OTHER: __________________________

CIRCLE ETHNICITY: HISPANIC/LATINO NON-HISPANIC/LATINO

CIRCLE PREFERRED LANGUAGE: ENGLISH SPANISH OTHER

INSURANCE PRIMARY: __________________________ ID# __________________________ GROUP# __________________________

SECONDARY: __________________________ ID# __________________________ GROUP# __________________________

**Do you have any allergies? (eggs, chicken, latex or medicines) Circle: YES NO

**Have you ever had a REACTION to a flu shot before? Circle: YES NO

**Do you currently have an active illness or are you taking antibiotics? Circle: YES NO

**Have you had Guillain-Barre Syndrome? Circle: YES NO

**Have you traveled outside of the US within the last 30 days? Circle: YES NO

**Have you been in contact with anyone who has traveled outside of US within the last 30 days? Circle: YES NO

If you answer "yes" to any of the above questions, please let the nurse know.

I HAVE READ OR HAD THE INFORMATION ABOUT THE INFLUENZA VACCINE EXPLAINED TO ME. I WAS GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I UNDERSTAND THE BENEFITS AND RISKS OF THE INFLUENZA VACCINE AND REQUEST THE VACCINE BE GIVEN TO ME OR THE PERSON FOR WHOM I AM AUTHORIZED TO MAKE THIS REQUEST. I UNDERSTAND THAT THE IMMUNES GIVEN TODAY WILL BE ENTERED INTO THE STATE DATA BASE, UNLESS I DECLINE. THE LAST FOUR DIGITS OF YOUR SOCIAL SECURITY NUMBER 5 SO THAT YOUR BILL WHEN SUBMITTED CAN BE READILY IDENTIFIED AND PAID.

X ______________________________________

PRINTED NAME ______________________________________

X ______________________________________

SIGNATURE OF PERSON RECEIVING VACCINE OR PARENT/GUARDIAN __________________________ DATE __________________________

AGENCY USE ONLY __________________________

PPSTOCK ONLY __________________________

FLU VACCINE SITE: ________

2020-2021 VIS GIVEN: ________ 8/15/2019

LOT# __________________________

EXP DATE: __________________________

FLUBLOK: ________

FLUZONE QUAD: ________

HIGH DOSE: ________

SIGNATURE OF NURSE ADMINISTERING VACCINE: __________________________

9/4/2020
RICHD CHILD FLU CONSENT

FULL NAME: ____________________________

First Name ___________________________ M ___________ Last Name ___________________________

DATE OF BIRTH: ________________________ AGE: ___________

CIRLCE GENDER

STREET ADDRESS: ____________________________ CITY: __________________________

STATE: _______ ZIP CODE: ____________ PHONE NUMBER: ___________________________

CIRCLE ETHNICITY: HISPANIC/LATINO NON-HISPANIC/LATINO

CIRCLE PREFERRED LANGUAGE: ENGLISH SPANISH OTHER

CIRCLE RACE: WHITE BLACK/AFRICAN-AMERICAN ASIAN AMERICAN INDIAN OTHER: __________________________

INSURANCE PRIMARY: ____________________________ ID# ___________ GROUP# ___________

SECONDARY: ____________________________ ID# ___________ GROUP# ___________

**Do you have any allergies? (eggs, chicken, latex or medicines) Circle: YES NO

**Have you ever had a REACTION to a flu shot before: Circle: YES NO

**Do you currently have an active illness or are you taking antibiotics? Circle: YES NO

**Have you had Guillain-Barre Syndrome? Circle: YES NO

**Have you traveled outside of the US within the last 30 days? Circle: YES NO

**Have you been in contact with anyone who has traveled outside of US within the last 30 days? Circle: YES NO

If you answer "yes" to any of the above questions, please let the nurse know

JOINT NOTICE OF PRIVACY PRACTICES GIVEN

I HAVE READ OR HAD THE INFORMATION ABOUT THE INFLUENZA VACCINE EXPLAINED TO ME. I WAS GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I UNDERSTAND THE BENEFITS AND RISKS OF THE INFLUENZA VACCINE AND REQUEST THE VACCINE BE GIVEN TO ME OR THE PERSON FOR WHOM I AM AUTHORIZED TO MAKE THIS REQUEST. I UNDERSTAND THAT THE IMMUNES GIVEN TODAY WILL BE ENTERED INTO THE STATE DATA BASE, UNLESS I DECLINE. THE LAST FOUR DIGITS OF YOUR SOCIAL SECURITY NUMBER IS SO THAT YOUR BILL WHEN SUBMITTED CAN BE READILY IDENTIFIED AND PAID.

X __________________________

PRINTED NAMED

X __________________________

SIGNATURE of person receiving vaccine or parent/guardian

DATE __________________________

AGENCY USE ONLY

VFC

VFC FLUZONE QUAD 6-35MTHS (2YRS11MTHS): __________

PP

FLUZONE QUAD __________

VIS GIVEN ________

8/15/2019

LOT# __________

EXP DATE: __________

2020-2021 __________

SIGNATURE OF NURSE ADMINISTERING VACCINE: __________________________

9/4/2020

Office Use Only: BILLING
Clinic Site: __________
Payment: ________ cash/check/cc# __________
Medicare __________ Private Insurance __________ IPA Child ________
Bill Township ________
Bill County for Employee/dependent: ________
VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): What you need to know

1 Why get vaccinated?

Influenza vaccine can prevent influenza (flu).

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

Each year thousands of people in the United States die from flu, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2 Influenza vaccine

CDC recommends everyone 6 months of age and older get vaccinated every flu season. Children 6 months through 8 years of age may need 2 doses during a single flu season. Everyone else needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine does not cause flu.

Influenza vaccine may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:
- Has had an allergic reaction after a previous dose of influenza vaccine, or has any severe, life-threatening allergies.
- Has ever had Guillain-Barré Syndrome (also called GBS).

In some cases, your health care provider may decide to postpone influenza vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.
4 Risks of a vaccine reaction

- Soreness, redness, and swelling where shot is given, fever, muscle aches, and headache can happen after influenza vaccine.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13), and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call 9-1-1 and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call 1-800-822-7967. VAERS is only for reporting reactions, and VAERS staff do not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at www.hrsa.gov/vaccinecompensation or call 1-800-338-2382 to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit CDC’s www.cdc.gov/flu
To Whom It May Concern:

The Rock Island County Health Department (RICHDO) will be providing your flu clinic this fall, please remember the following:

- It is your (organizations) responsibility to maintain the 6 foot social distancing rule, regulatory mask wearing, and controlling the line both incoming and outgoing
- You will need to consider and implement how you would like to manage and maintain the traffic of arriving and leaving guests; ie whom will go in what order
- All paperwork will need to be COMPLETED prior to our arrival
- RICHDO will not be providing clipboards/pens/etc and there will be no space for group gatherings
- Please remind your patrons to wear appropriate clothing (short sleeves or a shirt/top/sweater that can slip down their shoulder), there will no longer be time for people to ‘partially’ disrobe, they must come prepared