Drive on thru, Prevent the Flu!

Get your flu shot while helping us practice our community emergency response plan!

- **Bicknell**
  - Tuesday, Sept 22
  - 3:30 - 6:30 pm
  - Bicknell EMS Shed

- **Monroe**
  - Friday, September 25
  - 4 - 6:30 pm
  - Monroe Fire Station

- **Nephi**
  - Wednesday, Sept 23
  - 11 - 5 pm
  - Nephi EMS Shed

- **Fillmore**
  - Monday, Sept 28
  - 2 - 6 pm
  - Fillmore Fire Station

- **Mt. Pleasant**
  - Thursday, Sept 24
  - 2 - 6 pm
  - Mt. Pleasant Fire Station

- **Richfield**
  - Tuesday, Sept 29
  - 1 - 6 pm
  - Richfield EMS Shed

- **Salina**
  - Wednesday, Sept 30
  - 2 - 6 pm
  - Salina Fire Station

- **Junction**
  - Thursday, Oct 1
  - 4 - 6 pm
  - Piute High School

- **Eureka**
  - Monday, Oct 5
  - 4:30 - 7 pm
  - Eureka Fire Station

- **Manti**
  - Tuesday, Oct 6
  - 4 - 7 pm
  - Manti Fire Station

- **Gunnison**
  - Wednesday, Oct 7
  - 2 - 6 pm
  - Gunnison Fire Station

- **Delta**
  - Thursday, Oct 8
  - 2 - 6 pm
  - Delta Fire Station

No cost with most insurances, $25 with no insurance.
We accept cash, check, cards, & HSA

* Wear a short-sleeved shirt
* Shorts for little ones
* Fill out form on back to save time

(435)896-5451
www.centralutahpublichealth.org

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**CENTRAL UTAH PUBLIC HEALTH DEPT.**

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*Working for Healthy Communities*
# Central Utah Public Health Department Registration Form

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Female</th>
<th>Date of Birth</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Mailing Address:</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone#</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Race: Please circle one</th>
<th>White</th>
<th>Asian</th>
<th>African American</th>
<th>Alaskan Native</th>
<th>Pacific Islander</th>
<th>Native American</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Hispanic</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>VFC: Medicaid #</th>
<th>For Office Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Native American/Native Alaskan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adult Medicaid #</th>
<th>Medicare HMO Name</th>
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</table>

<table>
<thead>
<tr>
<th>Insurance:</th>
<th>PEHP</th>
<th>Select</th>
<th>Tall Tree</th>
<th>DMBA</th>
<th>PCN</th>
<th>EMI</th>
<th>BCBS</th>
<th>Humana PPO</th>
<th>United</th>
<th>TriCare</th>
<th>Cigna</th>
<th>Aetna</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Insurance #</th>
<th>Group</th>
<th>Name of Insured</th>
<th>Relationship</th>
<th>Insured Date of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Self Pay Amount:</th>
<th>Cash</th>
<th>Check#</th>
<th>Credit Card</th>
<th>Receipt #</th>
</tr>
</thead>
<tbody>
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</table>

Please answer the following questions:

1. Is the person to be vaccinated sick today?  
   Yes  No
2. Does the person to be vaccinated have an allergy to eggs, gelatin, thimerosal or other vaccine component?  
   Yes  No
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?  
   Yes  No
4. Has the person to be vaccinated ever had Guillain-Barre Syndrome?  
   Yes  No

I certify that the information I have provided is true and accurate. I have been given a copy and have read, or have had explained to me, the information contained in the Vaccine Information Statement about the disease. I have had a chance to ask questions, where were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) indicated be given to the person named above for who I am authorized to make the request.

I agree that the information form may be shared with schools, daycare centers, health care providers and others when deemed medically necessary.

I hereby release the Central Utah Public Health Department and their employees from all claims arising from such immunizations. I authorize Medicaid or insurance benefits to be paid to the Central Utah Public Health Department or its authorized agent and for CUPHD or its authorized agent to release information to Medicaid or insurance companies as necessary to claims, Medicare & Insurance. **I understand that I may be liable for all or a portion of the bill.**

**Notice of Privacy Practices and Acknowledgement of Receipt  Effective April 14, 2003**

The notice of Privacy Practices tells you how CUPHD may use or disclose information about you. Not all situations will be described. CUPHD is required to inform you of our privacy practices for the information we collect and keep about you. **I have been given a copy of CUPHDS’s Notice of Privacy Practices and have had a chance to ask questions about how information can be used.**

**Signature of patient or parent/guardian**  

**FOR OFFICE USE ONLY:**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Lot #</th>
<th>Dose</th>
<th>Site</th>
<th>Vaccinator Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>VFC Flu 6-35 mo 90685</td>
<td>.25 mL</td>
<td>LVL</td>
<td>RVL</td>
<td></td>
</tr>
<tr>
<td>VFC Flu &gt;3 yrs - &lt;19 yrs 90686</td>
<td>.5 mL</td>
<td>LD</td>
<td>RD</td>
<td></td>
</tr>
<tr>
<td>Flu &gt; 6 mo 90686</td>
<td>.5 mL</td>
<td>LVL</td>
<td>RVL</td>
<td></td>
</tr>
<tr>
<td>FluMist 90672</td>
<td>.5 mL</td>
<td>Nasal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FluBlok 50-65 90673</td>
<td>.5 mL</td>
<td>LD</td>
<td>RD</td>
<td></td>
</tr>
<tr>
<td>Flu- High Dose 90662</td>
<td>.5 mL</td>
<td>LD</td>
<td>RD</td>
<td></td>
</tr>
</tbody>
</table>

**TIME IN ___________**  
**TIME OUT ___________**

Flu VIS 08/26/2020