FLU SHOT CLINICS
FOR COUNTY EMPLOYEES

The vaccine is Trivalent

Wednesday, October 4, 2017
Lancaster County Extension Office
7:30 a.m. — 9:00 a.m.

Thursday, October 5, 2017
County/City Building – Room 112 (Main Chambers)
555 South 10th Street
7:30 a.m. — 9:00 a.m.

Tuesday, October 10, 2017
County/City Building — Room 113
8:00 — 9:30 a.m.

*County Employee Cost = None
(Wellness Program Benefit)

To help expedite the process, please have your consent form filled out prior to your arrival. Also, please dress appropriately (easy access to upper arm area) to facilitate receiving the flu immunization.
*The on-site clinics are for EMPLOYEES ONLY.

Employees who cannot make the on-site clinics may go to:
Kohll’s Pharmacy
800 N. 27th Street (North 27th and Vine)
Hours of operation are M – F  8:00 a.m. to  7:00 p.m.
Saturday 9:00 a.m. to 2:00 p.m.

OR

Medicap Pharmacy
2555 Kensington Dr.

Hours of operation are M-F  9:00 a.m. to 6:00 p.m.
Saturday 9:00 a.m. to 1:30 p.m.

Also, spouses may go to the pharmacy and receive
a flu shot. It will be $16.90 per person for the Trivalent
No checks will be accepted – cash only

Just a reminder

If you are pregnant or nursing, you must have a doctor’s note authorizing the administration of the influenza vaccine.
Influenza Vaccination Assessment, Release & Consent Form

The following information is to be completed by individual receiving the immunization.
Please print legibly.
Date ______/_____/_______ Corporation Name ____________

Name ___________________________ Date of Birth ______/_____/______ Sex Male Female

Phone ( ) ______-_________ Home Address ___________________ City ______ State __ Zip ______

Are you a spouse/domestic partner of an employee? If yes, please list their name: _____________________________

Insurance Policy Identification Number: ____________________________________________________

PLEASE CIRCLE THE ANSWERS TO THE FOLLOWING QUESTIONS:

1. Have you ever had a severe reaction to any vaccine? YES NO
2. Do you have any severe drug or food allergies? YES NO
   If yes, are you allergic to EGGS, CHICKEN OR CHICKEN FEATHERS? YES NO
   If yes, are you allergic to THIMEROSAL, NEOMYCIN OR GELATIN? YES NO
   If yes, are you allergic to POLYMYXIN B, KANAMYCIN OR GENTAMICIN? YES NO
   If yes, are you allergic to POLYSORBATE 20 or 80 OR HYDROCORTISONE? YES NO
3. Do you have any substantial fever, diarrhea or vomiting? YES NO
4. Are you allergic to latex? YES NO
5. Women: Have you had a mastectomy? YES NO
6. Women: Are you pregnant or nursing? YES NO

If you answered YES to any of the above, the healthcare professional will have to determine if this vaccine is right for you.

I have read the above information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and the risks of the influenza vaccine and ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. I authorize billing of this vaccination to my health insurance. If for any reason my insurance does not pay for the vaccination, I agree to pay the full amount of the procedure.

Signature ___________________________________________ Date ______/_____/_______

Please do not write below this line. To be completed by nurse personnel.

Vaccine Manufacturer          Lot#          Exp. Date          Dose Admin          Admin Site          Admin By

☐ FLUVAL      ✔               / /          ☐ 0.5ML          ☐ LT DT
☐ AFLURIA     / /          ☐ 0.25ML          ☐ RT DT
☐ FLUCELVAX    / /          ☐ 0.25ML          ☐ RT THIGH
☐ OTHER       / /          ☐ 0.25ML          ☐ LT THIGH

Nurse: if payment was received at clinic, please list. Check # _______________ Cash amount: ____________________