Carson City Flu Shot Walk-Up Clinic

For PEBP members enrolled in the Consumer Driven Health Plan (PPO) and PEBP Premier Plan (EPO)

PHOTO ID, INSURANCE CARD, and MASK ARE REQUIRED

Flu Shots: No out-of-pocket costs for PEBP Consumer Driven Health Plan and PEBP Premier Plan participants and their covered dependents. Flu shots are available to covered dependent children six months and older with a parent present.

Pneumonia Shots: Available only to those who meet CDC criteria. No out-of-pocket costs for PEBP Consumer Driven Health Plan and PEBP Premier Plan Participants and their covered dependents who also meet the CDC criteria.

How the Event Works: Please complete the double sided consent form before arrival. You may park in the back (east) parking lot and then walk-up to the tent. Please do not congregate in groups and follow the social distancing procedures.

"Getting a flu vaccine is more important than ever during 2020-2021 to protect yourself, your family, and your community from flu. A flu vaccine this season can also help reduce the burden on our healthcare systems responding to the COVID-19 pandemic and save medical resources for care of COVID-19 patients." - Centers for Disease Control and Prevention

Date:	**Monday, October 26th**
Time:	**9:00 AM – 12:00 PM** (no appointment needed)
Location:	**Richard H. Bryan Building East Parking Lot** 901 S. Stewart St. Carson City, NV 89701
Who:	**CDHP and EPO members six months and older**

Administrative leave is authorized per NAC 284.589.6(b) for **active employees** attending a PEBP coordinated event. PEBP recommends employees work with their supervisor to request approval to attend a flu clinic.

PEBP
NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Hometown Health

FLU/PNEUMONIA CONSENT 2020/2021

Last Name	First Name	MI	Date of Birth	Age

Address	City, State	Zip Code	County	☐ Male ☐ Female

Phone Number (__ __ __) -- __ __ __ -- __ __ __ __	Primary Care Physician

Name and/or address change in the last year? ☐ ***Yes*** ☐ ***No***

IF YES, Previous Name _____ Previous Address _____

Do you have a history of Guillian-Barre Syndrome? (Neurological paralyzing disease)	Yes ☐ No ☐
Are you ill today? (If yes, you should not receive vaccines today)	Yes ☐ No ☐
Have you ever had a severe anaphylactic reaction to eggs? (If yes, you should not receive a flu shot)	Yes ☐ No ☐
Do you smoke or have asthma?	Yes ☐ No ☐
Have you received Prevnar 13?	Yes ☐ No ☐
Have you received Pneumonia 23?	Yes ☐ No ☐

Consent and Release statement

I have read or have had explained to me the information on the fact sheet about Influenza and/or Pneumococcal vaccine. I have has a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of Influenza and Pneumococcal vaccine and request that the vaccine(s) be given to me or to the personal named above for which I am authorized to make this request. I understand that is I have a reaction, I am to consult my physician. I understand this information will be entered into an EMR**. I give permission to have my blood tested for HIV and other blood borne bacteria and viruses in the vent a health care worker is exposed to my bodily fluids that may result in the transmission of blood borne diseases**. If I misrepresent my insurance coverage, I am responsible for all administration fees and full cost of vaccines.

X _____ **X** _____

SIGNATURE OF PERSON TO RECEIVE VACCINE/PARENT OR LEGAL GUARDIAN DATE

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have had made available to me the opportunity to receive the Notice of Privacy Practices of Renown Health.

X_____ **X**_____

Signature of Patient or Personal Representative* *Relationship to patient

X_____ **X** _____ / _____ / _____

Print Name Date

FLU/PNEUMONIA CONSENT 2020/2021

DO NOT WRITE ON THIS AREA **FOR CLINICAL STAFF USE ONLY** **DO NOT WRITE IN THIS AREA**

Hometown Health/Senior Care Plus HMO PPO	Insurance Number: __ __ __ __ __ __ __ __ __ __ __
Medicare (NAME and NUMBER printed exactly on card)	Card Name: Card Number: __ __ __ __ - __ __ __ - __ __ __ __
Other Insurance	Insurance Number: Group Number:
Bill to Company	Name of Company:
Self-Pay (Name of patient)	Amount Received: $_____ ☐ Cash ☐ Check ☐ Credit Card

State Vaccine (Highlight if patient is to receive state funded vaccine)

Immunizations: z23

3 yrs+ **QUAD (prefilled)** CPT code 90686	☐	65 yrs**+ HIGH DOSE**, CPT code 90662	☐
		PNEUMONIA 23, CPT code 90732	☐

VACCINE	DATE GIVEN	MANUFACTURER LOT NUMBER/EXP DATE	SITE/ROUTE	CLINIC SITE	ADMINISTERED BY (first initial, last name, title)	VIS DATE
Influenza			IM: RD LD RT LT			8/15/19
Influenza **HD**			IM: RD LD RT LT			8/15/19
Pneumonia 23			IM: RD LD RT LT			10/30/19

Clerical PAR signature & Date:

X _____ **X** ____ / ____ / _____