



Drive Thru  
Flu shots

# Drive on thru, Prevent the Flu!

Please Join the Central Utah Public Health Department, along with many first responder agencies in the community as we practice our Mass vaccination plans. Flu shots will be offered in a fast and convenient “drive-thru” method.

## Make the STOP, get the SHOT!

### NEPHI

When: September 13, 2017  
Time: 1:00 pm - 6:00 pm  
Where: Juab EMS Building  
about 100 N. 100 E., Nephi

### RICHFIELD

When: September 14, 2017  
Time: 12:00 pm - 5:30 pm  
Where: Sevier EMS Building  
50 Westview Dr., Richfield

### PIUTE

When: September 15, 2017  
Time: 4:00 pm - 7:00 pm  
Where: Piute High School  
about 550 N. Main., Junction

### MT. PLEASANT

When: September 19, 2017  
Time: 2:00 pm - 6:00 pm  
Where: Mt. Pleasant Fire Station  
115 W. Main., Mt. Pleasant

### DELTA

When: September 20, 2017  
Time: 1:00 pm - 6:00 pm  
Where: Delta Fire Station  
98 W. Main., Delta

### WAYNE

When: September 21, 2017  
Time: 3:00 pm - 6:00 pm  
Where: Wayne EMS Building  
115 N. SR 24., Bicknell

### FILLMORE

When: September 25, 2017  
Time: 3:00 pm - 6:00 pm  
Where: Fillmore Fire Station  
25 E. 100 S., Fillmore

### MANTI

When: September 26, 2017  
Time: 2:00 pm - 6:00 pm  
Where: 52 S. 100 E.  
Manti, Utah

### EUREKA

When: October 4, 2017  
Time: 5:00 pm - 7:00 pm  
Where: Eureka Fire Station  
440 E. Main., Eureka

**Cost:** Flu shot is typically free with your insurance card or \$25 without.

Most insurances Accepted. For more information, call your local office.

**We Accept Cash, Check, HSA, & Credit Cards!**

[WWW.CENTRALUTAHPUBLICHEALTH.COM](http://WWW.CENTRALUTAHPUBLICHEALTH.COM)

You can fill out the form online and bring it with you, or fill it out at the site.



Working for Healthy Communities



## Central Utah Public Health Department Registration Form

Last Name	First Name	Female Male	Date of Birth	Age		
Mailing Address	City	State	Zip	Phone#		
Race: (Please circle one)	White	Asian	Black	Pacific Islander	Native American/Alaskan Native	Other
Hispanic Yes No						

For Office Use Only					
VFC: Medicaid# _____	No insurance	Native American/Native Alaskan	Underinsured	Chip	
Adult Medicaid # _____	Medicare # _____	Medicare HMO Name: _____			
Insurance: PEHP	Select	Tall Tree	DMBA	PCN	EMI BCBS Humana PPO United TriCare Cigna
Insurance #: _____	Group #: _____				
Name of Insured: _____	Relationship _____				
Self-Pay Amount: Cash _____	Check # _____	Credit Card _____	Receipt # _____	CLERK'S INITIAL _____	

### Please answer the following questions:

- |   |     |    |
|---|-----|----|
| * Is the person to be vaccinated sick today? (fever or very stuffy nose)                                    | Yes | No |
| * Does the person to be vaccinated have an allergy to eggs, gelatin, thimerosal or other vaccine component? | Yes | No |
| * Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?*            | Yes | No |
| * Has the person to be vaccinated ever had Guillain-Barré syndrome?   | Yes | No |
| * Is the person to be vaccinated pregnant?  | Yes | No |

SCREENER'S INITIAL \_\_\_\_\_

### CONSENT FOR TREATMENT AND PRIVACY NOTICE

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 (VIS) about the disease. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine(s) indicated be given to the person named above for whom I am authorized to make this request.

I agree that this information 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. 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 tell 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 CUPHD's Notice of Privacy Practices and have had a chance to ask questions about how my information could be used.**

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of patient or parent/legal guardian.

Vaccine	Lot #	Dose	Site	Vaccinator Signature
VFC Flu 6 - 35 mo 90685		.25 mL	LVL RVL	
VFC Flu >3 - <18 yrs 90686		.5 mL	LD RD	
Flu 6 - 35 mo 90685		.25 mL	LVL RVL	
Flu >3 - <18 yrs 90686		.5 mL	LD RD	
Flu - High Dose >65 yrs 90662		.5 mL	LD RD	