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!

When: September 23, 2014
Time: 1:00 pm - 5:30 pm
Where: Sevier EMS Building
50 westview Dr. Richfield

When: September 25, 2014
Time: 12:00 pm - 5:00 pm
Where: Juab EMS Building
about 100 N. 100 E. Main, Nephi

When: September 29, 2014
Time: 1:00 pm - 6:00 pm
Where: Mt. Pleasant Fire Station
115 W. Main, Mt. Pleasant

When: October 3, 2014
Time: 2:30 pm - 7:30 pm
Where: Piute High School
about 550 N. Main, Junction

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
You can fill out the form online and bring it with you, or fill it out at the site.
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>
<td></td>
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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>
</table>

| Would you like to be the first to know when seasonal flu vaccine is available? |
| Email: |

<table>
<thead>
<tr>
<th>Race: (Please circle one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
</tr>
<tr>
<td>Native American/Alaskan Native</td>
</tr>
</tbody>
</table>

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

RECEIVING FLUMIST (AGES 2 - 49 only) – please also answer the following questions

* Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, liver disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?  
  Yes No

* Does the person to be vaccinated have a weakened immune system or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with drugs or radiation?  
  Yes No

* If the person to be vaccinated is a child younger than 5 years old, have they been told they have asthma or had one or more episodes of wheezing within the past year?  
  Yes No

* If a child or adolescent, is the person to be vaccinated receiving long-term aspirin therapy?  
  Yes No

* Does the person to be vaccinated have any muscle or nerve disorders (such as seizure disorders or cerebral palsy) that can lead to breathing or swallowing problems?  
  Yes No

* Will person to be vaccinated be in close contact with someone whose immune system is so weak they require care in a protected environment (such as a bone marrow transplant unit)?  
  Yes No

* Is the person to be vaccinated receiving antiviral medications?  
  Yes No

* Has the person to be vaccinated received MMR, Varicella (chickenpox), Yellow Fever, or seasonal flu mist in the last 4 weeks?  
  Yes No

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.

X_________________________ Date__________________

Signature of patient or parent/legal guardian.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Lot#</th>
<th>Dose</th>
<th>Site</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu Mist</td>
<td></td>
<td>0.2 mL</td>
<td></td>
<td>Intranasal</td>
</tr>
<tr>
<td>Flu – inject.</td>
<td>.5 mL</td>
<td>.25 mL</td>
<td>.1 mL</td>
<td>LD RD LVL RVL ID</td>
</tr>
</tbody>
</table>

Flu VIS 08/19/2014

08/19/2014