Insurance Claim Form PEBB/OEBB Consent Influenza Immunization

| Insurance Plan: | Providence Health Plan | Moda | Kaiser | Other | | | | | | |
|--|-----------------------------|-------------|------------|-------------------------|---------------|-----------------------|------------|--------|------------|--|
| Primary Insurance # | | | | | | | | | | |
| Secondary Insurance | # | | | | | | | | | |
| | | | | | | | | | | |
| Last Name | | | | | | | | | | |
| First Name | | | | | | | | | | |
| Your Street Addr | ess where you receive | your insura | ance pap | erwork (| not your emai | il address | ;) | | | |
| City | | | | | | State | ZIF | P Code | | |
| Telephone (000-000-0000) Date of E | | | of Birth(| f Birth(Month/Day/Year) | | | Gender | | | |
| | | | | | | Male | Female | Not I | Identified | |
| Have you ever h | ad a flu vaccination before | e? Yes | No | Unsure | Are you alle | rgic to a c | omponent | | | |
| Have you ever had a severe reaction to a flu shot? | | Yes | No | of the vaccine? | | Yes | No | | | |
| Do you have a history of Guillain-Barre Syndrome? Are you feeling sick today? | | | Yes Yes | | Are you preç | Are you pregnant? Yes | | | No | |

| Signature of responsible person | Relationship to Insured | | | Date Signed | | |
|----------------------------------|--------------------------------|--------|---------|-------------|--|--|
| | Self | Spouse | Child | | | |
| | | | E NOTES | | | |
| Clinic Name | | NURS | ENOTES | | | |
| Date of Vaccination: | VIS 8/6/2021 | | | | | |
| Mfg/Lot #: Expiratio | on Date: | | | | | |
| Nurse's Initials: Site of Inject | ion: L R Deltoid | | | | | |