Polly Klement, FNP-C Krystal Bewley, FNP-C
909 North Frontage Rd Valley View, TX 76272
Phone- 940-726-5750 Fax- 940-726-5721

FLU CLINIC COMING TO VALLEY VIEW ISD

Valley View Family Medical Clinic wants to help us stay healthy this fall and winter with an onsite flu-shot clinic.

WHEN: Tuesday October 19th 8:15 A.M. -10:15 A.M.

WHO CAN RECEIVE A FLU SHOT: Vaccinations will be available to staff and family ages 3 years and up. Each year's active influenza strains are different, so you need to get the 2021-2022 shot to be protected-even if you got a flu shot last year.

COST: VVFMC accepts most PPO insurance for flu vaccines: Aetna, Cigna, Blue Cross Blue Shield, UMR, United Healthcare, Medicare and many others. If you have a question about your policy, you can call VVFMC at 940-726-5750. For them to bill your insurance, they need a front and back copy of your insurance card as well as a copy of your ID (parent's ID students without ID.) Medicaid and self-pay cost is $35 per shot.

To participate, please fill out the attached flu vaccine consent form . To participate fill out the following forms and send payment or copy of insurance card with forms.

Krystal Bewley, FNP-C Polly Klement, FNP-C Chance Dingler, MD
909 North Frontage Road Valley View, TX 76272
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FLU VACCINE CONSENT FORM

Patient Name: ______________________________ Date of Birth: ____________________

Male ☐ Female ☐ Age: ________ Primary Phone: ____________________________

Address: ____

City: _________________________________ State: _____________ Zip: ___________

Have you had a fever in the last 72 hours or are you feeling ill today? **YES / NO**
Do you have an allergy to eggs or Thimerosal preservative? **YES / NO**
Have you ever been diagnosed with Guillain Barre Syndrome? **YES / NO**
Have you ever had a reaction to the influenza vaccine or any other vaccine in the past? **YES / NO**
Do you have asthma or an immune deficiency disease? **YES / NO**
Are you pregnant or breastfeeding? **YES / NO**

I, the undersigned, have read or had explained to me the vaccine information sheet (VIS). I understand the risks and benefits associated with the influenza vaccine and have had any questions satisfactorily answered. I voluntarily request that the vaccine be given to me to me or for the person for whom I am authorized to make this request.

Signature: _________________________________ Date: ________________________

FOR OFFICE USE ONLY

Date Given: ________________ Route Given: ________ Site: ☐ RD ☐ LD ☐ RT ☐ LT

Manufacturer: ________________ Lot #: ________________ Exp Date: ________________

Administered by: ____

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Patient Name: ______________________________ Date of Birth: __________________

Mailing Address: ____

City and State: ______________________________ Zip: ____________________

Primary Phone: ______________________ Alternate Phone: ______________________

Gender: ____________________ Age: ____ SSN: ______________________________

Email Address: ________________________________ (required for patient portal account)

Ethnicity/Race: ______________________ Preferred Language: ____________________

Previous Physician (including location): ____

Preferred Pharmacy (including location):____

Employer: ________________________ Employer Phone: ________________________

Parent/Guardian: ____________________ Parent/Guardian Date of Birth: _____________

Emergency Contact Name & Phone: ____

Emergency Contact Name & Phone: ____

How did you hear about Valley View Family Medical Clinic?: _________________________

I hereby authorize the release of medical information necessary to process my insurance claim and assign the doctor all payments from Medicare and other insurance carriers for services rendered. I also understand that I am responsible for the balance of my account. I understand and agree to the above conditions.

Patient Signature: ______________________________________ Date: ________________