

VACCINE ADMINISTRATION RECORD
(In Compliance with HIPAA)

NAME: _____ Date of Birth: _____ Age: _____
 (Last) (First) (MI)

Address: _____ Phone: () - _____
 (Street) (City) (State) (Zip)

Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Are you allergic to eggs? | <input type="checkbox"/> Are you taking Coumadin or Theophylline medication? |
| <input type="checkbox"/> Are you sick today? | <input type="checkbox"/> Do you have a chronic illness? |
| <input type="checkbox"/> Have you ever had Guillain-Barre Syndrome? | <input type="checkbox"/> Have you ever had a reaction to a flu shot? |
| <input type="checkbox"/> Are you a health care worker? | <input type="checkbox"/> Are you a caregiver of a child < 6 months of age? |
| <input type="checkbox"/> Are you pregnant? | <input type="checkbox"/> Have you received any other vaccines in the last 4 weeks? |

For Medicare and Medicaid Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Medicare Beneficiary Claim Number _____

Medicaid Claim Number _____

I have read or have had explained to me the information in the pamphlet about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request. Further, I hereby consent, for myself or for the person for whom I am authorized to act, to the use and disclosure of protected health information contained in the vaccine administration records, including disclosures to my physician, for the purposes of treatment, payment (if applicable), and health care operations. I have received a copy of the Notice of Privacy Practices of the Lorain County General Health District and the latest Influenza Vaccine Information Sheet (VIS). I understand this record will be kept on file with the health district.

Signature _____ Date _____

How did you hear about us? (circle one) newspaper radio website flu line family

FOR CLINIC USE ONLY

Please indicate form of payment below if applicable:				
Cash/check	Bill to:	Employee/Family	N/C	Response Partners
Age Groups	0-18	19-49	50-64	65+
Clinic Location:				

Date Administered	Vaccine Manufacturer	Vaccine Lot Number	Site of Injection: R Del L Del R Thigh L Thigh
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Signature and Title of Vaccine Administrator: _____