VACCINE ADMINISTRATION RECORD

Information about person to receive vaccine Male Female

NAME: Last First MI Birth date Age

ADDRESS: Street City Zip

Home/cell Phone Number **MEDICARE NUMBER** Physician

_____ (please initial) I have been informed about the HIPAA Information. xx

1. Is person to be vaccinated Diabetic? ___ Yes ___ No _____

2. Is the person to be vaccinated sick today? ___ Yes ___ No ___ Don't know

3. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? ___ Yes ___ No ___ Don't know

4. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? ___ Yes ___No ___ Don't know

5. Has the person to be vaccinated ever had *Guillian-Barre* syndrome? ___ Yes ___No ___ Don't know

I have read or have had explained to me the information about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe 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.

_____ _____

Patient Signature/ Authorized signature **Date**

State Employees Only:

Must show proof of State Health Insurance

With respect to your social security number, note the following: The provision of a flu shot is a gratuitous one being made to you by your employer. You do not have to participate. If you do, we request that you provide us with the last four digits of your social security number so that your bill when submitted can be readily identified and paid. The request of the last four digits of your social security number is voluntary in nature and is not mandated by any statute. These digits, along with other information on this form, will be used to facilitate prompt payment to the health care provider and in any other manner consistent with HIPAA, state and federal statute and regulations. Therefore, information will be kept confidential as required by HIPAA and all other state and federal statutes and regulations.

Health Department Use only

State employee / Department _____ County Employee _____

Clinic _____ Date_____ RN/LPN_____ Site_____ Manufacturer