2022-2023

Inactivated Injectable Influenza Vaccine Administration Form

Client Information

PLEASE WRITE LEGIBLY.

Last Name	First Name	M.I.	*Date of Birth*	*Age*	*Sex* ☐ *Male* ☐ *Female*
Address	City/Township	State	*Zip*	*County*	
Phone: May we leave a message? ☐ Yes ☐ No	Parent/Guardian Name (only if client is under age 18)	*Race (for statistical use only)* ☐ *Asian Pacific* ☐ *White* ☐ *Other* ☐ *Black* ☐ *Native American*		*Hispanic?* ☐ *Yes*	
Email Address	Emergency Contact: First Name, Last Name, Phone#	*Language* ☐ *English* ☐ *Other:*___________________			

Answer a few short questions so we can make sure that the vaccine can be given today

☐ Yes ☐ No ☐ Don't Know Is the person to be vaccinated sick today?

☐ Yes ☐ No ☐ Don't Know Does the person to be vaccinated have an allergy to a component of the vaccine?
If Yes, List allergies:

☐ Yes ☐ No ☐ Don't Know Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?

☐ Yes ☐ No ☐ Don't Know Has the person to be vaccinated ever had Guillain-Barre' Syndrome?

Client Consent (or Parent/Guardian Consent for clients age 17 & under) - read and sign/date below.

I was given an explanation about the diseases and vaccines. I had the opportunity to ask questions that were answered to my satisfaction and/or received a Vaccine Information Sheet. I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or the person named above for whom I am authorized to make this request. I hereby consent that the Local Health Department (LHD), or designee, from whom I received the vaccination can bill my insurance, if applicable. I understand I am financially responsible for any fees not covered by my insurance company. I authorize the release of this record to the Ohio Department of Health Immunization Program. I hereby acknowledge receipt of the LHD Notice of Health Information Privacy Practice and give permission to release my immunization record to my doctor or agency/school. If indicated on this form, I authorize the LHD or designee to charge my account. For clients age 17 and under, parent and/or guardian consents to allow client to receive vaccine without parent and/or guardian present.

SIGN Name: X ______________________________ Date: ____________________

Payment Information (complete insurance OR self-pay area below)

INSURANCE – (complete insurance info below **AND** in box to the left write 1 or 2 to indicate primary/secondary)	SELF-PAY
☐ Medicare (Traditional Part B) ID# ______________________	☐ Cash
☐ Medicare HMO (ie, Anthem Medicare Advantage, Secure Horizons Medicare Advantage) Name of Plan: ______________ ID# ______________	☐ Check # ______________
☐ Medicaid (ie, Traditional Medicaid, CareSource, Molina, Paramount, UHC Community) Name of Plan: ______________ ID# ______________	☐ Credit Card Type ______________
☐ Private Insurance Company Name: ______________________	Acct# ______________
Member ID: ______________ Group: __________ Plan:__________	Exp. Date ______________
Policy Holder Name & Date of Birth: ______________ ___ ___ _____	Amount: ______________
Relationship to Policy Holder: ______________________	Receipt # ______________
☐ Other (ie, company voucher, etc) ID# ______________________	Received By: ______________

---------- Office Use Only ----------

Vaccine Administered Information — SC = subcutaneous IM = intramuscular ID = intradermal IN = intranasal

Date	Vaccine Name	Vaccine Lot #	Mfg	RA	LA	RT	LT	Nose	Dose (check box) 0.5 ml	0.2ml LAIV			Vaccinator Initials

Clinic site: **VIS:** ☒ **08/06/2021** **Vaccinator signature**