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VACCINE ADMINISTRATION FORM

Client Information

Last Name	First Name	M.I.	Date of Birth	Age	Sex
					☐ Male ☐ Female

Address	City/Township	State	Zip	County

Phone (if age under 18, phone of parent/guardian)	Parent/Guardian Name (only if client is under age 18)	Race (for statistical use only)	Hispanic?
		☐ Asian Pacific ☐ White ☐ Other ☐ Black ☐ Native American	☐ Yes

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

☐ Yes	☐ No	Is the client is sick today?
☐ Yes	☐ No	Is the client allergic to latex, medications, food, or any vaccines?
		→ IF YES, list the allergies: _____
☐ Yes	☐ No	Does the client have a history of Guillain-Barre syndrome?
☐ Yes	☐ No	Is the person receiving the flu vaccine 8 years old or under?
		→ IF YES, how many doses did the child receive the FIRST year they received flu vaccine? ☐ 1 ☐ 2 ☐ Not sure
☐ Yes	☐ No	Has the client had other vaccines or anti-virals in the last 30 days?
		→ IF YES, list the vaccines: _____
☐ Yes	☐ No	Does the client have history of wheezing and/or asthma?
☐ Yes	☐ No	Is the client pregnant or could possibly find out that she is pregnant in the next month?
☐ Yes	☐ No	Does the client have a weak immune system (ie, HIV, cancer, steroids) or have a chronic illness (ie, diabetes)?
		→ IF YES, list conditions: _____
☐ Yes	☐ No	Is the client taking long-term aspirin therapy or aspirin-containing therapy?

☐ Enrolled in Medicaid ☐ No health insurance ☐ Other private insurance ☐ Under-insured (vaccinations not covered)

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 ☐ Check # _____
Medicaid (ie, Traditional Medicaid, CareSource, Molina, Amerigroup) Name of Plan: _____ ID# _____	Amount: _____ Receipt # _____ 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	0.25 ml	0.2 ml	0.1 ml	Vaccinator Initials

Clinic site: **VIS:** ☐ **Flu 07/26/11** ☐ **FluMist 07/26/11** ☐ **PPSV23 10/06/09**

Regional Form Revised: 7/11/2011