

**INFLUENZA VACCINE ADMINISTRATION RECORD**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
 Last First MI

Address: \_\_\_\_\_  
 Street City State/Zip Code

Telephone: \_\_\_\_\_ Doctor: \_\_\_\_\_ Employer \_\_\_\_\_

**Payment Method** (Check ALL that Apply)

Bill To:  Client  Insurance  Self-Pay  Medicare  VFC

Business / Address: \_\_\_\_\_

Insurance Name: ID and Group \_\_\_\_\_

Are you ill today?	Yes	No
Have you received a flu shot before?	Yes	No
Did you have a severe reaction following the shot?	Yes	No
Are you allergic to eggs?	Yes	No
Have you ever been diagnosed with Guillian-Barre Syndrome?	Yes	No

I have read or have had explained to me the Vaccine Information Sheet about the influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the risks and benefits of influenza vaccine and request that the vaccine be administered to me or to the person named above for whom I am authorized to make this request. I hereby acknowledge that a copy of the Clinton County Health Department Notice of Privacy Practices has been available to me. I understand this document provides information on how my health information may be used or disclosed by the Clinton County Health Department and my rights with respect to my health information.

For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the Clinton County Health Department.

I grant permission for this record to be released to medical providers, health departments, schools, day-care centers, and other as is necessary. I attest that all information on this form is accurate and I am responsible for all costs incurred at the time of each appointment services are rendered with the signature provided below.

X \_\_\_\_\_  
 Signature of person to receive vaccine or authorized representative Date

**FOR OFFICE USE ONLY**

Date Administered: \_\_\_\_\_ Vaccine Manufacture: SP

Lot Number UI826AD Site of Injection: RT LT RD LD  
 VIS Date 8-7-15

Vaccine Administrator: MW CW DB MS EM **PRIVATE BUSINESS SELF-PAY**

**Clinton County Health Department  
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