



# VACCINE ADMINISTRATION FORM

## Client Information

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

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

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the client is sick today?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the client allergic to latex, medications, food, or any vaccines? IF YES, list the allergies: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a history of Guillain-Barre syndrome?
<input type="checkbox"/> Yes	<input type="checkbox"/> 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? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not sure
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has the client had other vaccines or anti-virals in the last 30 days? IF YES, list the vaccines: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have history of wheezing and/or asthma?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the client pregnant or could possibly find out that she is pregnant in the next month?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a weak immune system (ie, HIV, cancer, steroids) or have a chronic illness (ie, diabetes)? IF YES, list conditions: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the client taking long-term aspirin therapy or aspirin-containing therapy?

## 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 <b>AND</b> in box to the left write 1 or 2 to indicate primary/secondary)		SELF-PAY
Medicare (Traditional Part B) ID# _____		<input type="checkbox"/> Cash
Medicare HMO (ie, Anthem Medicare Advantage, SecureHorizons Medicare Advantage) Name of Plan: _____ ID# _____		<input type="checkbox"/> Check # _____
Medicaid (ie, Traditional Medicaid, CareSource, Molina, Paramount, UHC Community) Name of Plan: _____ ID# _____		<input type="checkbox"/> Credit Card Type _____ Acct# _____ Exp. Date _____
Private Insurance Company Name: _____ Member ID: _____ Group: _____ Plan: _____ Policy Holder Name & Date of Birth: _____ / ____ / ____ Relationship to Policy Holder: _____		Amount: _____ Receipt # _____
Other (ie, company voucher, etc) ID# _____		Received By: _____

## Office Use Only

Vaccine Administered Information				SC = subcutaneous IM = intramuscular ID = intradermal IN = intranasal					Dose (check box)				Vaccinator Initials	
Date	Vaccine Name	Vaccine Lot #	Mfg	RA	LA	RT	LT	Nose	0.5 ml	0.25 ml	0.2 ml	0.1 ml		
Clinic site:				VIS: <input type="checkbox"/> Flu 08/19/2014 <input type="checkbox"/> Flu Mist 08/19/2014 <input type="checkbox"/> PPSV23 10/06/09										