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|  Client InformationVACCINE ADMINISTRATION FORM |  |  |  |
| 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) Asian Pacific White Other Black Native American | Hispanic? Yes  |

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| Answer a few short questions so we can make sure that the vaccine can be given today |
| * Yes
 | * No
 | Is the client sick today? |
| * Copy of NAACHO_PH_2C_NoTagLogo_000.jpgYes
 | * No
 | Is the client allergic to latex, medications, food (i.e. eggs, gelatin), 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, has the child received 2 total doses of influenza vaccine before July 1, 2016? |
| * Yes
 | * No
 | Has the client had other vaccines or anti-virals in the last 30 days?IF YES, list the vaccines: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Enrolled in Medicaid No Health Insurance Other Private Insurance Under-insured (vaccinations not covered) |

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| 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:  |

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| Payment Information(complete insurance OR self-pay area below) |
| INSURANCE –(complete insurance info below) | SELF-PAY |
|  | Medicare (Traditional Part B) ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  Cash h Check # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Receipt # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Received By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Medicare HMO (ie Anthem Medicare Advantage, Secure Horizons Medicare Advantage)  Name of Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Private Insurance Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan: \_\_\_\_\_\_\_\_\_\_\_ Policy Holder Name & Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_\_ Relationship to Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Medicaid (ie, Traditional Medicaid, CareSource, Molina, United Healthcare Community Plan)Name of Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

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| **Vaccine Administered Information: Injection Route: S=Subcutaneous,(not to be used for influenza) or I=Intramuscular** |
| **Date** | **Vaccine Name** | **Vaccine Lot #** | **Mfr** | **RA** | **LA** | **RT** | **LT** | **Dose** |  | **Administered By** |
| **0.25ml** | **0.5ml** |
|  | **Fluzone (ages 6-35 mo)** | **U5599AC** | **GSK** |  |  |  |  | **X** |  |  |  |
|  | **Fluzone (ages 6-35 mo)** |  | **GSK** |  |  |  |  | **X** |  |  |  |
|  | **Fluarix QIV(ages 3-18 yrs)** | **TS5F3** | **GSK** |  |  |  |  |  | **X** |  |  |
|  | **Fluarix QIV(Adults VFC)** | **TS5F3** | **GSK** |  |  |  |  |  | **X** |  |  |
|  | **Fluarix QIV (Private 3 yrs +)** | **2RG54** | **GSK** |  |  |  |  |  | **X** |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| **Clinic site: Darke County General Health District** | **VIS: Flu 08/07/15** Regional Form Revised: 09/13/2016 |