|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client Information  VACCINE 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 |

|  |  |  |
| --- | --- | --- |
| 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, 2017? |
| * 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, Buckeye Health Plan, Paramount Advantage, 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** | **RD** | **LD** | **RT** | **LT** | **Dose** | |  | **Administered By** |
|  | **0.5ml** |
|  | **Fluarix – Private** | **C559A** | **GSK** |  |  |  |  |  | **X** |  |  |
|  | **FluLaval - VFC** | **PN75E** | **GSK** |  |  |  |  |  | **X** |  |  |
|  | **Fluarix – 317** | **TL54R** | **GSK** |  |  |  |  |  | **X** |  |  |
|  |  |  |  |  |  |  |  |  | **X** |  |  |
|  |  |  |  |  |  |  |  |  | **X** |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |
| **Clinic site: Darke County General Health District** | | | **VIS: Flu 08/07/15** Regional Form Revised: 09/7/2017 | | | | | | | | |