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) ☐ 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?

☐ Yes ☐ 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)

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)	SELF-PAY
☐ Medicare (Traditional Part B) ID# _____	☐ Cash ☐ Check # _____ ☐
☐ Medicare HMO (ie Anthem Medicare Advantage, Secure Horizons Medicare Advantage) Name of Plan: _____ ID# _____	Amount: _____ Receipt # _____ Received By: _____
☐ 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 ----------

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 0.5ml		Administered By
									X	
									X	
									X	
									X	
									X	

Clinic site: Darke County General Health District **VIS:** ☐ **Flu 08/07/15**

Regional Form Revised: 09/7/2017