

Client Information

VACCINE ADMINISTRATION FORM

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 (if age under 18, phone of parent/guardian)		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

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 Are you currently under quarantine for COVID-19?

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, 2020?

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# _____	<input type="checkbox"/> Cash
Medicare HMO (ie Anthem Medicare Advantage, Secure Horizons Medicare Advantage) Name of Plan: _____ ID# _____	<input type="checkbox"/> Check # _____
Private Insurance Company Name _____ Member ID# _____ Group: _____ Plan: _____ Policy Holder Name & Date of Birth: _____ / / _____ Relationship to Policy Holder _____	<input type="checkbox"/>
Medicaid (ie, Traditional Medicaid, CareSource, Molina, Buckeye Health Plan, Paramount Advantage, United Healthcare Community Plan) Name of Plan: _____ ID# _____	Amount: _____ Receipt # _____ Received By: _____

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		Administered By
									0.5ml	
	Flulaval – VFC	42DT9	GSK						X	
	Flulaval – VFC		GSK							
	Flulaval – Private	CF4GR	GSK						X	
	Flulaval – Private		GSK							
	Flulaval – VFC	4BH32	GSK						X	
	Fluarix – 317	9S4K5	GSK							
	Fluarix – 317	4PA3X	GSK						X	

Clinic site: Darke County General Health District

VIS: Flu 08/15/19

Regional Form Revised: 09/14/2020

