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, 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, 2024?

☐ 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)

Medicare (Traditional Part B) ID# _____

Medicare HMO (ie Anthem 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, United Healthcare Community Plan etc.)
Name of Plan: _____ ID# _____

SELF-PAY

☐ Cash
☐ Check # _____
☐
Amount: _____
Receipt # _____
Received By: _____

Clinic site: Darke County General Health District | **VIS:** ☐ **Flu 08/06/21** | Regional Form Revised: 07/23/2024

Vaccine Administered Information: **Injection Route:** **Im=Intramuscular**

Date	Vaccine Name	Vaccine Lot #	Mfr	RD	LD	RT	LT	Dose 0.5ml		Administered By
	Flulaval – Private	**33G3M**	**GSK**						**0.5 ml**	
	Flulaval – VFC	**495MK**	**GSK**						**0.5 ml**	
	Fluarix - 317	**N737Y**	**GSK**						**0.5 ml**	
	Fluzone High Dose-65 +	**UT8473DA**	**Sanofi**						**0.7 ml**	