2020 VACCINE ADMINISTRATION RECORD

Information about person to receive vaccine Male Female

NAME: Last First MI Birth date Age

ADDRESS: Street City Zip

Home/Cell Phone Physician **MEDICARE B/ Medicaid NUMBER**

_____ (please initial) I have been informed about the HIPAA Information.
_____ (please initial) Reviewed Vaccine Information Sheet (given or refused). Current VIS edition dated 8/15/2019 (CDC)
_____ (please initial) I understand that I am responsible for any balance after my insurance has processed the claim.

1. Is person to be vaccinated Diabetic? ___ Yes ___ No __ Don't know
2. Is the person to be vaccinated sick today? ___ Yes ___ No __ Don't know
3. Is person to be vaccinated on antibiotics? ___ Yes ___No
4. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? ___ Yes ___ No __ Don't know
5. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? ___ Yes ___No ___ Don't know
6. Has the person to be vaccinated ever had *Guillian-Barre* syndrome? __ Yes ___No ___ Don't know

I have read or have had explained to me the information about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

_____ _____

Patient Signature/ Authorized signature **Date**

State Employees Only: Must show proof of State Health Insurance

With respect to your social security number, note the following: The provision of a flu shot is a gratuitous one being made available to you by your employer. You do not have to participate. If you do, we request that you provide us with the last four digits of your Social Security Number so that your bill, when submitted, can be readily identified and paid. The request for the last four digits of your Social Security Number is voluntary in nature and is not mandated by any statute. These digits, along with the other information on this form, will be used solely to facilitate prompt payment to the health care provider. Thereafter, information will become part of your healthcare records and will be kept confidential as required by HIPAA and all other federal statutes and regulations. The information will not be divulged without your consent or used for any purpose other than facilitating payment. If you choose not to disclose the last four digits of your Social Security Number, please provide either your home address and/or date of birth.

Health Department Use Only

State employee / Department _____ County employee/ Department _____

Last 4 SSN_____

Check appropriate vaccine Lot #

Clinic _____ Date_____ **Manufacturer/Lot #/Exp. Date:** _____

Nurse_____ Site RA / LA **Vaccine type (circle):** Regular High Dose 65+

Medicare Medicaid MCO Insurance Cash Check _____