

## 2022 VACCINE ADMINISTRATION RECORD

<b><u>Information about person to receive vaccine</u></b>				Male	Female
NAME: Last		First	MI	Birth date	Age
ADDRESS: Street		City		Zip	
Home/Cell Phone	Physician	<b>MEDICARE B/ Medicaid/ Insurance NUMBER</b>			
_____ (please initial) I have been informed about the HIPAA Information.					
_____ (please initial) Reviewed Vaccine Information Sheet (given or refused). <span style="color: red;">Current VIS edition dated 8/6/2021 (CDC)</span>					
_____ (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 <i>Guillian-Barre</i> 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.

State employee / Department \_\_\_\_\_ County employee/Department \_\_\_\_\_

Last 4 SSN \_\_\_\_\_

**Health Department Use Only**

Clinic _____	Date _____	<b>Manufacturer/Lot #/Exp. Date:</b> _____			
Nurse _____	Site RA / LA _____	<b>Vaccine type (circle):</b>		Regular	High Dose or Adjuvanted (65+)
	Medicare	Medicaid	MCO	Insurance	Cash      Check _____