Ashland County Health Department

1211 Claremont Avenue
Ashland, OH 44805
419-282-4357

INFLUENZA VACCINE ADMINISTRATION RECORD

Name:	Birth Date:	Age:	Sex: M F

Social Security #:	Address:

City:	State:	Zip Code:	Phone:

PLEASE ANSWER THE FOLLOWING QUESTIONS:	YES	NO
Are you sick today?		
Are you allergic to a preservative called thimerosal?		
Have you had an allergic reaction to medications, food, or vaccines?		
Have you ever had a serious reaction after receiving a vaccination?		
Is this your first time to ever get a flu shot?		
For females: Are you pregnant or is there a chance you could become pregnant?		
Do you have a history of Guillain-Barre' syndrome?		

VFC Eligibility – for age 6 months – 18 years

Is your child enrolled in Medicaid/Healthy Start?	Yes		No	
Is your child currently without any health insurance?	Yes		No	
Is your child American Indian or Alaskan Native?	Yes		No	
Is your child covered by health insurance that has no vaccine coverage?	Yes		No	

PLACE A CHECK OR INITIAL BESIDE EACH OF THE FOLLOWING STATEMENTS:

	I have received a copy of the influenza vaccine information sheet.
	To the best of my knowledge, I understand the benefits and/or risks of the influenza vaccine.
	I have had a chance to ask questions about that vaccine that were answered to my satisfaction.
	I request to receive the influenza vaccine, or request the vaccine be given to the above-named individual for whom I am authorized by law to make said request.

I understand that my insurance will be billed for services that I/my child receives from The Ashland County Health Department and that I am responsible for any co-pay or deductible imposed by, or charges not covered by my policy. Each insurance policy is unique, and I understand that some services may not be covered. I understand that my information released will be treated as confidential by the HD, in accordance with the HD's HIPPA policies.

Signature of person receiving vaccine or person authorized to make the request (parent/guardian):

X____ **Date:** ____________________

OFFICE USE:

Amount Paid $________ Cash ___ Check # ________ Credit/Debit ___ Not Collected Receipt # ________

Company to be billed: ______________________________ Clerk Initial ________

Insurance: Insurance # Group #

Clinic Site:	Injection Site LD RD LT RT	Intranasal IM	Lot# Expiration Date:		Nurse's signature RN
Date:	Amount 0.5 ML 0.7 ML	Manufacturer:		Sanofi Pasteur GSK Medimmune Other: ____________	

For Ages ________ Single-dose syringe Multi-dose Vial Single-dose vial VFC State Private High-Dose