

- 6-35 months old
- K-12
- Mist (2-49)
- Shot (36 mos. +)
- Intradermal (18-64)
- High Dose (65+)

Place Label Here

\*\*\*For Office Use Only\*\*\*

## FLU SHOT/ FLUMIST VACCINE ADMINISTRATION RECORD

“I have read or have had explained to me the information in the Vaccine Information Statement (VIS). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the 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.”

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT IN BLUE OR BLACK INK)				
NAME: LAST		FIRST		M.I.
STREET ADDRESS:		CITY	COUNTY	STATE ZIP
PHONE	SOCIAL SECURITY# (Optional)	MARITAL STATUS		GENDER M or F
DATE OF BIRTH	AGE	RACE	SCHOOL (if applicable)	GRADE (if applicable)
SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE REQUEST AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE (NPP) FORM:				
X _____			DATE _____	
<b>(If vaccine recipient is under 18 years of age, fill out the shaded section below)</b>				
<b>Parent or Guardian Name:</b> Last		First	Middle Initial	Maiden

**If Medicare Part B is your primary insurance, please complete the information below:**

EXACT NAME ON MEDICARE CARD \_\_\_\_\_

MEDICARE # \_\_\_\_\_

AUTHORIZATION SIGNATURE TO BILL \_\_\_\_\_

IF INSURANCE DOES NOT PAY FOR VACCINE, PATIENT WILL BE RESPONSIBLE FOR PAYMENT.

### FOR OFFICE USE ONLY

Form checked, insurance card seen (Name & Part B) VIS given and NPP witnessed by \_\_\_\_\_ (Initials)

BILL MEDICARE PART B ONLY \_\_\_\_\_

PAID \$ \_\_\_\_\_ CASH  CHECK  # \_\_\_\_\_ RECEIPT# \_\_\_\_\_ CREDIT CARD  CASHIER INITIALS \_\_\_\_\_

CC TYPE: Visa/ MasterCard /Other CC# \_\_\_\_\_ EXP DATE: \_\_\_\_\_ CC SECURITY# \_\_\_\_\_

**Please turn page over and complete side 2**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Please check <i>Yes</i> or <i>No</i> to the following questions:	Yes	No
1. Are you allergic to chicken eggs? Chicken feathers? Chicken dander?		
2. Are you allergic to thimerosal (mercury derivative) preservative?		
3. Do you have a history of Guillain-Barré Syndrome?		
4. Have you ever had a reaction to ANY VACCINE?		
5. Do you have a fever or other illness today?		

**\*\*\*\*\*Continue ONLY if you are receiving FluMist\*\*\*\*\***

6. Are you 2 – 49 years old?		
7. Do you have a medical history of chronic or long-term illness involving: the lungs (like ASTHMA or cystic fibrosis) kidney, liver, heart, nervous system or brain (including muscle disorders) metabolic system (like diabetes) blood system (like anemia) or immune system (like HIV infection, AIDS, cancer, etc.)?		
8. Are you allergic to Gentamicin, MSG, arginine or gelatin?		
9. Are you taking medicine containing aspirin?		
10. Does someone in the household have severe immune problems whose care must be provided in a protective environment (e.g., transplant receipt etc).		
11. Have you received any vaccines during the past 4 weeks? Are you scheduled to receive any vaccines during the next 4 weeks?		
12. Are you pregnant?		

**\*\*\*\*\*FOR CLINIC/OFFICE USE ONLY\*\*\*\*\***

Queen Anne’s County Department of Health Alternate site:  
 206 North Commerce Street  
 Centreville, MD 21617

Date of VIS	8/7/2015	8/7/2015
VACCINE GIVEN:	Influenza Vaccine (circle one) High –Dose/Intradermal / 0.5ml / 0.25ml	Flu Mist (LAIV4)
DATE ADMINISTERED:		
MANUFACTURER:	Sanofi	MedImmune
LOT NUMBER & EXPIRATION DATES:	Lot #: _____ Exp. date: _____	Lot #: _____ Exp. date: _____
SITE OF ADMINISTRATION:	Circle one <span style="margin-left: 50px;">Deltoid / Thigh</span> Circle one <span style="margin-left: 50px;">R / L</span>	Intranasal

SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR: \_\_\_\_\_