INFLUENZA

INFORMATION ABOUT THE PERSON TO RECEIVE THE INFLUENZA VACCINE

FIRST NAME:	MIDDLE NAME:	LAST NAME:	DATE OF BIRTH:

STREET ADDRESS:	BOX #	CITY/STATE/ZIP:

HOME PHONE:	CELL PHONE:	MAIDEN NAME: (If Applicable)

COUNTY:	STATE YOU WERE BORN IN:	GENDER: □ Male □ Female	RACE:

QUESTIONS MUST BE ASKED PRIOR TO IMMUNIZATION ADMINISTRATION

Is the person to be vaccinated:	YES	NO	DON'T KNOW
1. Sick Today?			
2. Have any allergy to a component of the vaccine?			
3. Ever had a serious reaction to influenza vaccine in the past?			
4. Ever had Guillain-Barre Syndrome?			

TOBACCO USE (Circle One):	CURRENT	FORMER	NEVER
SECOND HAND SMOKE EXPOSURE (Circle all that apply)	HOME	WORK	NONE

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS:

A copy of the appropriate Centers for Disease Control and Prevention **Vaccine Information Statement(s)** has been provided. I have read, or have had explained, the information about the disease(s) and the vaccine(s) listed. There was an opportunity to ask questions and all questions were answered satisfactorily. I believe that I understand the benefits and risks of the vaccine(s) cited and ask that the vaccine(s) listed be given to the person named above (for whom I am authorized to make this request).

If I am the Client, or an individual legally obligated to pay for medical service provided to the client or a guarantor of payment, **I agree to pay and I am financially responsible** for the Local Public Health Unit's established charges provided to the client not covered by a third-party payer. I assign and **authorize any third party payer/insurer** to make direct payment to the Local Public Health Unit for all benefits payable for the client's care. **I authorize the release of any medical or other information necessary to process this claim.**

X _____ **Signature of person to receive vaccine or person authorized to make the request**	**DATE:**

VACCINE	INJECTION SITE	PRIVATE/STATE	LOT NUMBER
INFLUENZA:			
OTHER:			
OTHER:			

RN SIGNATURE		DATE:	TIME:

CLINIC SITE:	□ Copy of Ins. Card on File	Primary Insurance	Policy Holder:

Policy Number:	Group Number If applicable	Policy Holder's Date of Birth