VACCINE ADMINISTRATION FORM

Client Inform	mation													
Last Name			First Nan	First Name				M.I.		Date of Birth		Age	Sex Male Female	
Address			City/Tow	City/Township			State		Zip	County				
Phone (if age und	[Whit	e e Americar] Other	Hispanic? Yes No			
Answer a few short questions so we can make sure that the vaccine can be given today														
☐ Yes ☐ No Is the client sick today?														
☐ Yes	→ IF YES, list the allergies:													
☐ Yes														
Yes	➤ IF YES, how many doses did the child receive the FIRST year they received flu vaccine? ☐ 1 ☐ 2 ☐ Not sure													
☐ Yes ☐ No Has the client had other vaccines or anti-virals in the last 30 days? ➤ IF YES, list the vaccines:														
☐ Yes ☐ No Does the client have history of wheezing and/or asthma?														
☐ Yes														
☐ Yes	☐ Yes ☐ No Does the client have a weak immune system (ie, HIV, cancer, steroids) or have a chronic illness (ie, diabetes)? ➤ IF YES, list conditions:													
☐ Yes		nt taking long-terr	m aspirin th	nerapy (or aspi	rin-cor	ntainin	g thera	py?				1	
☐ Enrolled		No health insurance		her pri			_			red (vac	cinatic	ns not	covered)	
								_		·				
Client Cons	ent (or Parent/Gua	dian Consent for d	clients age '	17 & un	ider) -	read an	d sign/c	late belov	ν.					
understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or the person named above for whom I am authorized to make this request. I hereby consent that the Local Health Department (LHD), or designee, from whom I received the vaccination can bill my insurance, if applicable. I understand I am financially responsible for any fees not covered by my insurance company. I authorize the release of this record to the Ohio Department of Health Immunization Program. I hereby acknowledge receipt of the LHD Notice of Health Information Privacy Practice and give permission to release my immunization record to my doctor or agency/school. If indicated on this form, I authorize the LHD or designee to charge my account. For clients age 17 and under, parent and/or guardian consents to allow client to receive vaccine without parent and/or guardian present. SIGN Name:														
										f.	1			
Payment Information (complete insurance OR self-pay area below)														
INSURANCE — (complete insurance info below <u>AND</u> in box to the left w					te 1 or 2 to indicate primary/secondary)					SELF-PAY				
Medica								☐ Cash						
Medicare HMO (ie, Anthem Medicare Advantage, SecureHorizons Medicare Advantage)														
Name of Plan: ID# Medicaid (ie, Traditional Medicaid, CareSource, Molina, Amerigroup)									☐ Credit Card					
Name of Plan: ID#									Туре					
Private Insurance Company Name:								Acct#						
Member ID: Group: Plan:									Exp. Date					
Policy Holder Name & Date of Birth: / / /									Amount:					
Relationship to Policy Holder:								Receipt #						
Other (ie, company voucher, etc) ID#									Received By:					
Vaccine Ad	= subcutaneous IM = intramuscular = intradermal IN = intranasal													
Date	Vaccine Name	Vaccine Lot #	Mfg	RA	RA LA		RT LT		Dose (check box) 0.5 ml			Vaccinator Initials		
			-						0.5 ml	0.25 ml	0.2 ml	0.1 ml	iiiidais	
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Clinic site:			VIS:] Flu 8	5/6/21		<u> </u>							