# Alabama Department of Public Health
# Influenza Vaccine Administration Form

## PATIENT INFORMATION

| Last Name | First Name | M.I. | Gender |
|---|---|---|---|
| | | | |

| Race | American Indian or Alaskan Native? | Date of Birth | Age |
|---|---|---|---|
| | ☐ YES ☐ NO | | |

| Street Address | Phone |
|---|---|
| | |

| City | County | State | Zip Code |
|---|---|---|---|
| | | | |

For school vaccine clinic, list school and check **one** vaccine preference (*eligibility for FLUMIST is determined by questionnaire below*):

School: _____ ☐ FLUMIST (administered nasally) ☐ Injectable Vaccine

## PARENT / LEGAL GUARDIAN INFORMATION FOR DEPENDENTS

| Last Name | First Name | Relationship to Patient |
|---|---|---|
| | | |

| Street Address (if different) | City | State | Zip |
|---|---|---|---|
| | | | |

| Phone | Emergency Contact | Email |
|---|---|---|
| | | |

## INSURANCE INFORMATION

Insurance Provider (check one): ☐ BCBS ☐ ALL Kids ☐ Medicaid ☐ Medicare ☐ Blue Advantage ☐ Uninsured ☐ Other _____

| Group Number | Insurance Policy Number or Medicaid Number |
|---|---|
| | |

| Cardholder Name | Cardholder Date of Birth | Relationship to Patient |
|---|---|---|
| | | ☐ Self ☐ Parent ☐ Legal Guardian ☐ Spouse ☐ Other_____ |

## VACCINATION AND HEALTH-RELATED INFORMATION

| | |
|---|---|
| Has the patient ever received a flu vaccination? | YES NO |
| IF YES, was the flu dose received in the year 2010 or after? | YES NO |
| Is the patient pregnant or will the patient become pregnant within the next month? | YES NO |
| Is the patient younger than 5 years with asthma or one or more episodes of wheezing within the past year? | YES NO |
| Does the patient have long-term health problems with: (*Children with any of the conditions below will not meet requirements to receive FluMist.)* | YES NO |
| • Heart Disease • Lung Disease • Asthma<br>• Kidney or Liver Disease • Metabolic Disease, such as Diabetes • Anemia and other Blood Disorders | |
| Does the patient have certain muscle or nerve disorders (such as seizure disorders or cerebral palsy) that can lead to breathing or swallowing problems? | YES NO |
| Does the patient have a weakened immune system? | YES NO |
| Is the patient in close contact with someone whose immune system is weak and who requires care in a protected environment (such as a bone marrow transplant unit)? | YES NO |
| Does the patient have any life-threatening allergies, including a severe allergy to food (including eggs), a vaccine component, or latex? | YES NO |
| IF YES, please list: _____ | |
| Has the patient received vaccinations in the past 4 weeks? | YES NO |
| IF YES, please list: _____ | |
| Has the patient ever had a severe reaction after a dose of influenza vaccine? | YES NO |
| Has the patient had Guillain-Barré Syndrome (a severe paralytic illness, also called GBS)? | YES NO |

**FOR SCHOOL CLINICS** ***(check one):***

**If my child does not qualify for FluMist:**

☐ Please do not administer any other vaccine, I **only** want the FluMist.

☐ Please administer the alternative vaccine (injectable), I do not need to be contacted.

☐ Please contact me and discuss further.

I have read the Vaccine Information Statement (VIS) about the influenza virus and vaccine. I understand the benefits and risks of the influenza vaccine. I give permission for the above named patient to receive the vaccine indicated. I authorize billing insurance for the vaccine provided. I have also received notice of my privacy rights, and I have been given or offered a copy of the Alabama Department of Public Health "Notice of Privacy Practices." I understand this information is available upon request, as well as available for review at the time of vaccination.

_____ _____

Signature (Parent or Guardian if under 14, or if receiving vaccination at school clinic regardless of age) Date

## (FOR CLINIC USE ONLY)

| Date Vaccine and VIS Given | Type and Date of VIS | Clinic Site | County Code | NCES # |
|---|---|---|---|---|
| | | | | |

**Vaccine Given:** ☐ FLUMIST ☐ FLUARIX ☐ FLUZONE ☐ FLUZONE HD ☐ OTHER: _____ **VFC** ☐ YES ☐ NO

| Site Type | Manufacturer and Lot Number | NDC# | Site of Injection | Route |
|---|---|---|---|---|
| ☐ WELLNESS ☐ COUNTY CLINIC | | | LA RA LT RT | IM NASAL |

**Nurse Signature** ☐ Pregnant-Additional vaccine information received ☐ Second Dose Needed

*This form should be used for recording the administration of a vaccine when a Comprehensive Health Record (CHR) is not opened.