INFLUENZA VACCINE ADMINISTRATION RECORD & CONSENT

Adults 19 and older

Information about person to receive vaccine PLEASE PRINT:

_____ _____ _____/_____/_____
Last Name First Name **DATE OF BIRTH**

_____ _____ _____
Address Apt/Suite Age

_____ _____ _____ (_____) _____-_____
City State Zip Area Code & Phone Number

1.	Does person to be vaccinated have an allergy to eggs?	Yes	No
2.	Does the person to be vaccinated have an allergy to Gentamycin, latex, gelatin or thimerosal?	Yes	No
3.	Has the person to be vaccinated ever had a serious reaction to an influenza vaccine?	Yes	No
4.	Has the person to be vaccinated ever had Guillain-Barré Syndrome?	Yes	No
5.	Does the person to be vaccinated have a seizure disorder?	Yes	No
6.	Has the person to be vaccinated had asthma, wheezing or taken medicine for asthma (including inhalers) **in the past year**?	Yes	No
7.	Has the person to be vaccinated ever had a health problem with lung disease, heart disease, kidney disease, metabolic disease (e.g. diabetes), a blood disorder or is currently receiving aspirin therapy?	Yes	No
8.	Does the person to be vaccinated have cancer, leukemia, AIDS or any other immune system problem?	Yes	No
9.	Has the person to be vaccinated taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments (does not include x-rays) **in the past three (3) months**?	Yes	No
10.	Has the person to be vaccinated received a transfusion of blood or blood products or been given a medicine called immune (gamma) globulin **in the past year**?	Yes	No
11.	Is the person to be vaccinated pregnant or is there a chance she could become pregnant **during the next month**?	Yes	No
12.	Has the person to be vaccinated received a Measles Mumps Rubella (MMR), Varicella (chickenpox), Yellow Fever or FluMist vaccine **in the past four (4) weeks**?	Yes	No
13.	Does the person to be vaccinated have close contact with anyone who has a weakened immune system who is in the hospital **in a protective environment** (e.g. an individual who has had a bone marrow transplant)? Please describe: _____	Yes	No

Please turn over →

Please Circle (For Statistical Purposes Only)

A) **Sex:** Male Female
B) **Race:** White African American Asian/Pacific Islander Asian Indian Other
C) **Ethnicity:** Non Hispanic Hispanic Unknown

Insurance Information: (circle)

No insurance Private Insurance (Insurance Company:_____)

Medicaid (State Insurance) Railroad Medicare

Medicare/Railroad Clients Only:
Please read and sign below:
If Medicare denies payment for my claim for the Influenza Vaccine for any reason, I understand that I am financially responsible for the cost of the immunization. I understand that the Chester County Health Department will bill me the cost of the vaccine plus administrative fees.
Signature _____ Date_____

Consent:
I give permission to receive a 2014/15 influenza vaccine. I understand vaccine information may be shared with my primary care provider. I understand I have the right to revoke this consent anytime before the vaccine is given. I understand I have the right to review my health information. I received a copy of the Vaccine Information Statement.
Signature _____ Date_____

For Clinic/Office Use Only

Clinic Site: _____

Date Vaccine Administered: _____

Vaccine Manufacturer: Sanofi Pasteur GSK MedImmune

Lot Number_____ Exp. Date: _____

Dosage: 0.5cc (IIV) / .2cc (FluMist) VIS LAIV 8/19/14

Site of Injection: RD, IM LD, IM Intranasal IIV 8/19/14

Signature of Vaccine Administrator: _____

Payment Type:

Cash _____ Check _____ Railroad _____

Credit Card _____ No Charge _____ Medicare _____