INFLUENZA VACCINE ADMINISTRATION RECORD & CONSENT

Adult (19 years and above)

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

Information about person to receive vaccine PLEASE PRINT: (Medicare/RR clients please print name as it appears on the card)

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

_____ _____ _____
Address Apt/Suite **AGE**

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

Please answer the following questions.

1. Are you sick today?	Yes	No
2. Are you allergic to eggs?	Yes	No
3. Have you had an influenza vaccine in the past?	Yes	No
4. Have you ever had a serious reaction to an influenza vaccine in the past?	Yes	No
5. Are you allergic to Gentamycin, latex, gelatin or thimerosal?	Yes	No
6. Have you ever had Guillain-Barré Syndrome?	Yes	No
7. Have you ever had a health problem with asthma, seizures, lung disease, heart disease, kidney disease, metabolic disease (e.g., diabetes), or a blood disorder?	Yes	No
8. Do you have cancer, leukemia, AIDS, or any other immune system problem?	Yes	No
9. Have you taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments in the past 3 months?	Yes	No
10. Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No
11. Have you received any live vaccines (for example, MMR or varicella) vaccinations in the past 4 weeks, or do you plan to receive any within the next month? If yes, date and vaccine _____	Yes	No
12. Have you ever received the Pneumonia (Pneumococcal) vaccine? If yes, when? _____	Yes	No

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

Signature of person to receive vaccine or person authorized to make the request (parent/guardian)

X_____ DATE: _____

Please turn over →

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_____

For Clinic/Office Use Only

Clinic Site: _____

Date Vaccine Administered: _____

Vaccine Manufacturer: Sanofi Pasteur Novartis MedImmune

Lot Number_____

Dosage: 0.5cc (TIV) / .2cc (FluMist) / .1cc (Intradermal) Exp. Date: _____

Site of Injection: RD, IM LD, IM ID(Right) ID(Left) Intranasal

Signature of Vaccine Administrator: _____ VIS LAIV 7/2/12

VIS TIV 7/2/12

Medicare_____ ***RR_____***

Cash _____ ***Check_____***