First District Health Unit

www.fdhu.org

ADULT FLU VACCINE ADMINISTRATION RECORD – 2013/2014

Public Health
Prevent. Promote. Protect.

LAST NAME_____ **FIRST NAME**_____ **M.I.** _____

DATE OF BIRTH _____ **AGE**_____ **M**_____ **F**_____ **PHONE**_____

ADDRESS_____ **CITY**_____ **STATE**____ **ZIP**_____

INSURANCE COMPANY:_____

MEDICARE #:_____ **ADDRESS:**_____

MEDICARE PART D (PRESCRIPTION DRUG PLAN): _____

NAME OF PLAN:_____ **ID #:**_____**GROUP #:**_____

DRUG PLAN #:_____ **POLICY HOLDER NAME:**_____

MEDICAID NUMBER:_____ **POLICY HOLDER DATE OF BIRTH:**_____

Everyone, please answer all the questions in this box.

____Y____N Do you feel sick today?

____Y____N Have you had a serious reaction from a previous vaccination?

____Y____N Do you have any allergies to latex, food, medicine, or any vaccine? Please list allergies_____

____Y____N Have you ever had a seizure, convulsion or Guillain-Barre Syndrome (temporary severe muscle weakness)?

____Y____N Have you ever had a pneumonia vaccination?

Only answer these questions for a FluMist (nasal spray) instead of a shot. Must be 19 to 49 years old.

____Y____N Have you received MMR, chickenpox or shingles vaccine in the past 4 weeks? Date?_____ Vaccine?_____

____Y____N Do you have a long-term health problem: asthma; heart, lung, kidney, liver, neurological or neuromuscular disease; metabolic disease (diabetes); anemia; blood disorder? Please circle those that apply.

____Y____N Do you have a weakened immune system due to HIV/AIDS, cancer treatments, or other causes?

____Y____N Do you have close contact with a person who needs care in a protected environment, ie: bone marrow transplant?

____Y____N Are you pregnant?

AUTHORIZATION & ASSIGNMENT OF BENEFITS

A copy of the **Vaccine Information Statement(s) has been provided**, and I have read, or have had explained, the information about influenza (7/26/13) and or pneumonia (10/6/09). I had an opportunity to ask questions and believe that I understand the benefits and risks of the vaccine(s)**. I consent to the administration of the vaccines listed to be given to the person named above and I am authorized to give this consent.** First District Health Unit's (FDHU) **Notice of Privacy Practices** is available online or by request. **I agree to pay and I am financially responsible** for FDHU's established charges that are not covered by a third-party payer. I assign and **authorize any third party payer/insurer** to make direct payment to FDHU. I authorize the release of information necessary to process this claim**.** Information collected on this form will be used to document receipt of vaccine(s) and may be shared through the ND Immunization Information System (NDIIS) and other entities in accordance with ND Century Code 23-01-05.3.

SIGNATURE OF CLIENT OR PERSON AUTHORIZED TO SIGN ON THE CLIENT'S BEHALF:

X_____**DATE:**_____

FOR FDHU STAFF USE ONLY

METHOD OF PAYMENT: Flu injectable = $32 FluMist = $45 Pneumovax = $90/$76.10

☐ **SELF** ☐ **HMO** ☐ **EMPLOYER (Prior Approval Required)**

☐ **MEDICARE** ☐ **MEDICAID** ☐ **BILL INSURANCE** **EMPLOYER NAME**_____

___Influenza IM Lot #_____ **Fluvirin (Nov), Fluarix (GSK), Fluzone (SP) given IM Left / Right Deltoid.**

___FluMist-Lot#_____ **MedImmune given 0.2 cc intranasal.**

___Pneumovax Lot # _____ **Merck given IM in Left / Right Deltoid.**

Please circle manufacturer.

_____ _____ _____

Signature of Vaccine Administrator Date County

Amount Paid		Cash	Check#	Credit Card	Entered NDIIS	Entered KIPHS	Provider#		Revised 8/26/13