TUSCARAWAS COUNTY HEALTH DEPARTMENT

Influenza Vaccine Administration Record

Public Health
Prevent. Promote. Protect.

Date: _____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ SSN: _____ Age: Sex:

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: Cell Phone:

Insurance Name: _____

Subscriber's DOB: Subscriber's SSN:

Allergy to chicken eggs? Y N

Previous adverse reaction to a flu shot? Y N

By signing below, I understand that eligibility for coverage by my insurance company cannot be determined at this time. I understand that services provided today may not be covered by my insurance company. If it is determined that I am not eligible for coverage and no benefits exist for my claim, I understand that I will be responsible for payment of all services provided.

I have received information concerning influenza and pneumonia and the vaccine(s). I was given a chance to ask questions about influenza and pneumonia and I understand the benefits/risks of the vaccine. I ask that the influenza and/or pneumonia vaccine be given to me or to the person named on this form for whom I am authorized to make this request. I have been offered and/or received a copy of the Notice of Privacy Practices, confirmed by my signature below.

Patient Signature:

For Patients Under 18 Years Old

Parent/Guardian Name: _____

DOB: _____ SSN: _____

Patient Signature:

ADMINISTRATION DOCUMENTATION

Patient Name: _____ DOB: _____

Circle Medication Administered: Influenza High Dose Influenza Pneumovac 13 Pneumovac 23

	Private Stock	VFC Stock
Vaccine Manufacturer:		
Vaccine Lot Number:		
Expiration Date, if needed		
Site of Administration		
Signature of Vaccine Administrator		