# VACCINE ADMINISTRATION FORM

## Client Information

| Last Name | First Name | M.I. | Date of Birth | Age | Sex ☐ Male ☐ Female |
|---|---|---|---|---|---|
| | | | | | |

| Address | City/Township | State | Zip | County |
|---|---|---|---|---|
| | | | | |

| Phone (if age under 18, phone of parent/guardian) | Parent/Guardian Name (only if client is under age 18) | Race (for statistical use only) ☐ Asian Pacific ☐ White ☐ Other ☐ Black ☐ Native American | Hispanic? ☐ Yes ☐ No |
|---|---|---|---|
| | | | |

## Answer a few short questions so we can make sure that the vaccine can be given today

| | |
|---|---|
| ☐ Yes ☐ No | Is the client sick today? |
| ☐ Yes ☐ No | Is the client allergic to latex, medications, food, or any vaccines?<br>IF YES, list the allergies: _____ |
| ☐ Yes ☐ No | Does the client have a history of Guillain-Barre syndrome? |
| ☐ Yes ☐ No | Is the person receiving the flu vaccine 8 years old or under?<br>IF YES, how many doses did the child receive the FIRST year they received flu vaccine? ☐ 1 ☐ 2 ☐ Not sure |
| ☐ Yes ☐ No | Has the client had other vaccines or anti-virals in the last 30 days?<br>IF YES, list the vaccines: _____ |
| ☐ Yes ☐ No | Does the client have history of wheezing and/or asthma? |
| ☐ Yes ☐ No | Is the client pregnant or could possibly find out that she is pregnant in the next month? |
| ☐ Yes ☐ No | Does the client have a weak immune system (ie, HIV, cancer, steroids) or have a chronic illness (ie, diabetes)?<br>IF YES, list conditions: _____ |
| ☐ Yes ☐ No | Is the client taking long-term aspirin therapy or aspirin-containing therapy? |

☐ Enrolled in Medicaid ☐ No health insurance ☐ Other private insurance ☐ Under-insured (vaccinations not covered)

## Client Consent (or Parent/Guardian Consent for clients age 17 & under) - read and sign/date below.

I was given an explanation about the diseases and vaccines. I had the opportunity to ask questions that were answered to my satisfaction and/or received a Vaccine Information Sheet. I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or the person named above for whom I am authorized to make this request. I hereby consent that the Local Health Department (LHD), or designee, from whom I received the vaccination, can bill my insurance, if applicable. I understand I am financially responsible for any fees not covered by my insurance company. I authorize the release of this record to the Ohio Department of Health Immunization Program. I hereby acknowledge receipt of the LHD Notice of Health Information Privacy Practice and give permission to release my immunization record to my doctor or agency/school. If indicated on this form, I authorize the LHD or designee to charge my account. For clients age 17 and under, parent and/or guardian consents to allow client to receive vaccine without parent and/or guardian present.

SIGN Name: X _____ Date: _____

## Payment Information (complete insurance OR self-pay area below)

| | INSURANCE – (complete insurance info below **AND** in box to the left write 1 or 2 to indicate primary/secondary) | SELF-PAY |
|---|---|---|
| | Medicare (Traditional Part B) ID# _____ | ☐ Cash<br>☐ Check # _____ |
| | Medicare HMO (ie, Anthem Senior Advantage)<br>Name of Plan: _____ ID# _____ | |
| | Medicaid (ie, Traditional Medicaid, CareSource, Molina, Paramount, Buckeye, United Healthcare Community)<br>Name of Plan: _____ ID# _____ | |
| | Private Insurance Company Name: _____<br>Member ID: _____ Group: _____ Plan: _____<br>Policy Holder Name & Date of Birth: _____ ___ / ___ / _____<br>Relationship to Policy Holder: _____ | Amount: _____<br>Receipt # _____<br>Received By: _____ |

---------- Office Use Only ----------

| Vaccine Administered Information | | | | SC = subcutaneous IM = intramuscular ID = intradermal IN = intranasal | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Date | Vaccine Name | Vaccine Lot # | Mfg | RA | LA | RT | LT | Nose | Dose (check box) 0.5 ml | 0.25 ml | 0.2 ml | 0.1 ml | Vaccinator Initials |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| Clinic site: | | | VIS: ☐ Flu 08/15/19 ☐ PPSV23 10/30/2019 ☐ | | | | | | | | | | |