ALAMANCE COUNTY HEALTH DEPARTMENT
Flu Vaccine Administration Record

Information collected on this form will be used to document authorization for receipt of vaccine(s).

Name: Address: County of Residence: Race: Sex: Phone #: DOB and Age:	**Mother's Maiden Name** **Name of Parent or Guardian Responsible for Patient (if applicable** **Relationship to Patient**

Eligibility Status (Check only one) ☐ American Indian/Alaskan Native ☐ Underinsured ☐ Not Insured
This section must be completed for ☐ Medicaid (18 yrs and younger) ☐ Medicaid (19 +) _____
all state-supplied vaccines: ☐ NC Health Choice ☐ Insured (attach copy of card) ☐ Medicare
Cash_____ Check_____ Credit_____ _____
Clerk Initials

Please answer the following questions to determine if you can get the flu vaccine today:	**YES**	**NO**
1. Are you sick today?	☐	☐
2. Do you have an allergy to eggs?	☐	☐
3. Do you have allergies to medications, foods, or vaccine components? Please list:	☐	☐
4. Have you ever had a serious reaction after getting a vaccination?	☐	☐
5. Have you ever had a seizure, a brain problem, or other nervous system problem such as Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?	☐	☐

Please answer the following questions if you are 2-49 years of age. There are several kinds of influenza vaccines. Answers to the following questions will help us know which influenza vaccine you can get.

6. Have you received any other vaccinations in the past 4 weeks?	☐	☐
7. Do you think you are or could be pregnant?	☐	☐
8. Do you currently have any nasal infection (such as a sore, impetigo, fungal or staph infections in the nose)?	☐	☐
9. Have you taken antivirals (treatment for the flu) in the last 48 hours?	☐	☐
10. Do you have a long term health problem with heart disease, lung disease, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (such as diabetes) or blood disorder?	☐	☐
11. Have you ever been told by your doctor that you had wheezing or asthma?	☐	☐
12. Do you have a weakened immune system due to HIV/AIDS or another immune disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	☐	☐
13. Do you live with or expect to have close contact with a person whose immune system is severely compromised (i.e., someone who has recently had a bone marrow transplant) and who must be in protective isolation (such as in a hospital room with reverse air flow)?	☐	☐

Please answer the following question if your child is 8 years old or younger:

14. Since July 1, 2010, has your child received 2 or more doses of seasonal flu vaccine?	☐	☐

I am authorized by the parent, guardian, or person standing in loco parentis of the above-named child to obtain needed immunization for the child.

I voluntarily give my permission to receive influenza vaccine. I understand that payment for this service may be made in accordance with the provisions of Title XVIII of the Social Security Act (Medicare), and/or Title XIX of the Social Security Act (Medicaid), or by another third party payor. I hereby authorize the provider of service to release information necessary for the processing of any claim for payment made on my behalf, and I authorize payment to the provider for such claim.

I/parental designee have received the "Vaccine Information Statements" (VIS) about the disease(s) and vaccine(s). I have had a chance to review the VIS(s) and to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request the vaccine(s) indicated below to be given to me or the person named above for whom I am authorized to make this request.

SIGNATURE—Person to receive vaccine or person authorized to sign on the patient's behalf	**Date Signed**
X	

FOR ADMINISTRATIVE USE ONLY

Vaccine Indicated	**Notes**	**Name and Title of Screener**	**Date**
☐ IIV3 ☐ IIV4 ☐ Flu Mist ☐ High-dose ☐ Flublok ☐ State ☐ Private	☐ Parent advised 2nd dose recommended in 4 weeks		

Vaccine	**Trade Name**	**Lot #**	**Exp Date**	**VIS Pub Date**	**Body Route**	**Body Site**	**mL**
Seasonal Influenza				7/26/2013	IM Nasal	RD LD RVL LVL Nasal	0.25 0.5 0.2

RD = Right Deltoid LD = Left Deltoid IM = Intramuscular

SIGNATURE AND TITLE—Person Administering Vaccine	**Date Vaccine Administered**