Putnam County Health Department
Influenza/COVID **Vaccine Administration Record**

Patient Name ____ **Date of Birth** _____________________

Address ________________________________**City** ___________________ **ST** ____ **ZIP** _____________

Phone #______________________ **Age** ____ **Male**___ **Female** ___**Physician** ______________________

Please answer the following questions about the person to receive the vaccine:	**No**	**Yes**
• Are you sick today?		
• Have any allergies to medications, food, vaccine, latex? If yes, please list: ____		
• History of Guillain Barre Syndrome?		
• Serious reaction to Influenza of COVID-19 vaccine in the past?		
• Have leukemia, cancer, HIV/AIDS, or any other immune system problem?		
• Have a health problem with lung, heart, kidney, liver, diabetes, asthma, seizures, anemia or a blood disorder, no spleen, complement component deficiency, cochlear implant, spinal fluid leak, or on long-term aspirin therapy?		
• **FOR FLU MIST ONLY:** Could be pregnant or get pregnant in the next month?		
• Taken medications that affect the immune system, such as steroids, antiviral drug, drugs for rheumatoid arthritis, Crohn's disease, psoriasis, anticancer drugs or radiation in the past 3 months?		
• Had COVID-19 in the past 90 days?		
• **FOR COVID ONLY:** Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?		
• Have you received ANY doses of COVID-19 vaccine in the past? If yes, was your last COVID vaccine at least 8 weeks ago: YES NO		

Consent related to privacy notice: I have had a chance to review the Privacy Notice as part of this registration process. I understand the Terms of the Privacy Notice may change and I may get these changed notices by contacting PCHD by phone or in writing. I understand I have the right to ask how my protected health information will be used and/or given out. **The Privacy statement is displayed in the waiting area, and a copy can be given if requested by client. For off-site flu clinics, a copy is available, if requested, upon client registration.**

I have received a copy of the Influenza Vaccine Information and/or COVID statement. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I give permission for my name and birthdate to be released to state and federal Government for required reporting purposes.

Check One:

☐ I give permission for my insurance to be billed and accept financial responsibility according to insurance guidelines.

☐ I do not have or do not wish to bill insurance and will pay out-of-pocket at the time of service.

Signature of person to receive vaccine or person authorized to make the request (Parent or Guardian)	**Date**

Please attach copy of insurance card OR complete the following insurance information:
(Skip this section if insurance is not being billed for services)

Medicaid Billing ID Number ___________________________ **Group Number** _________________
Name of Medicaid Managed Care Company ____

Medicare Billing ID# _ ______________________________ **Group Number** ____________________
Name of Medicare Provider/Company ____

Primary Insurance Coverage
Name of Insurance Company ____
Name and Birth Date of Subscriber ____
ID # on insurance card ___________________________Group # on insurance card_______________
Address of Subscriber (if different than patient address) ___________________________________

Secondary Insurance Coverage
Name of Insurance Company ____
Name and Birth Date of Subscriber ____
ID # on insurance card ___________________________Group # on insurance card_______________
Address of Subscriber (if different than patient) ____

FOR OFFICE USE ONLY: Flu ☐ Flu Mist ☐ High-Dose Flu ☐ Covid-19 ☐

Manufacturer	Vaccine Lot #	Date Administered	Admin. Site	Dosage	Nurse Signature
SANOFI (65 and older)	UT8437BA U8515EA			0.5mL	
Sanofi (6mo and older)	UT8423JA U8518AA				
GSK (6mo and older)	T75MP 7KZ9R 495MK				
FLU MIST(ages 2-49)	WF2582				
Moderna (COVID) (ages 12 and older)	8080750 8080469				