PUTNAM COUNTY HEALTH DEPARTMENT
INFLUENZA (FLU) 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:	**YES**	**NO**
• Are you sick today?		
• Have any allergies to eggs, latex, Mercury, gelatin or other vaccine component?		
• Serious reaction to influenza vaccine in the past?		
• History of Guillain-Barre syndrome?		

FOR FLU MIST, COMPLETE AND ATTACH LONG-FORM QUESTIONNAIRE

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.
A copy of the Privacy statement is displayed in the waiting area, and a copy can be given if requested by client.

I have received a copy of the Influenza Vaccine Information 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.

Consent for assignment of benefits: I give permission for my insurance to be billed and acknowledge I am financially responsible for the patient responsibility according to my insurance guidelines -- all co-payments, deductibles, and other amounts that may be stated to be my responsibility by the insurance plan. It is my responsibility to get information from my health insurance agency about services that are not covered. If I receive care outside of my health insurance plan, I will be responsible for all charges due.
By signing this consent, I authorize the use and/or disclosure of my health information for treatment, payment or health care operations.

ATTACH INSURANCE CARD COPY TO THIS FORM

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

For office use only

Manufacturer	**Vaccine Lot #**	**Date Administered**	**Admin. Site**	**Dosage**	**Nurse Signature**
SANOFI (age 65 and older)	**U8830BA** **U8859AA**		Lt. Deltoid IM	0.5 mL	
GSK	**99H9A**		Rt. Deltoid IM	0.5 mL	
GSK	**4D255** **2CA5M Adult**		Lt. Thigh IM		
MIST	**YF3413**		Rt. Thigh IM	0.2 mL	