

**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:	YES	NO
• Are you sick today?		
• Have any allergies to eggs, latex, gelatin or vaccine component? If yes, please list: _____		
• Serious reaction to influenza or COVID-19 vaccine in the past?		
• History of Guillain-Barre syndrome?		
• Have a health problem such as: lung, heart, kidney, liver, diabetes, asthma, seizures, anemia or a blood disorder, no spleen, complement component deficiency, cochlear implant, spinal fluid leak, on a blood thinner or aspirin therapy?		
• Have leukemia, cancer, HIV/AIDS, or any other immune system problem?		
• 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?		
FOR FLU MIST ONLY:		
• Could you be pregnant or become pregnant in the next month?		
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?		
• Had COVID-19 in the past 90 days?		
• Have you received ANY doses of COVID-19 vaccine in the past?		
• If YES , was your last COVID vaccine at least 3 months ago?		

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 and/or COVID 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 my insurance plan. It is my responsibility to get information from my insurance provider about services that are not covered. If I receive care outside of my 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/Guardian)	Date

FOR OFFICE USE ONLY: Select all that apply and circle lot number to be administered.

FLU HIGH DOSE FLU FLU MIST (intranasal) COVID

Manufacturer	Vaccine Lot #	Date Administered	Admin. Site	Dosage	Nurse Signature
SANOVI (age 65 and older)	UT8763EA		Lt. Deltoid IM	0.5mL	
GSK (6mo and older)	99H9A		Rt. Deltoid IM		
GSK (6M and older)	4D255 2CA5M Adult ST Dose		Lt. Thigh IM	0.5mL	
INTRANASAL-FLU MIST (ages 2-49) AstraZeneca	YF3413 YF3413B		Rt. Thigh IM	0.2 mL	
Moderna (COVID) MNEXSPIKE (ages 12 and older)	3052733		Intranasal	0.2mL	