

INFLUENZA VACCINATION ASSESSMENT, CONSENT AND ADMINISTRATION RECORD

(PLEASE FILL IN ALL LINES COMPLETELY. PRINT YOUR NAME AS IT APPEARS ON YOUR INSURANCE CARD.)

Last name _____ First name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Phone _____ Doctor _____ Birth Date: _____

Circle one: Male or Female Have you had a seasonal flu shot before? Circle one: Yes No

Please indicate method of payment below:

Medicare Number _____

READ THE STATEMENTS BELOW AND SIGN AND DATE THE FORM.

Title 19 Number _____

READ THE STATEMENTS BELOW AND SIGN AND DATE THE FORM.

Do you have insurance that pays for flu & pneumonia shots?

Name of Insurance Company: _____

Insurance Co. Address & Phone Number: _____

Name on Insurance Card: _____

Policy Number _____ **Group Number** _____

Social Security Number of Person receiving flu shot: _____

READ THE STATEMENTS BELOW AND SIGN AND DATE THE FORM.

- I am not sick today. I have not had an allergic reaction to a flu shot in the past.
- I am not allergic to Thimerosal, a mercury containing preservative found in eye drops and contact solution.
- I do not have Guillain-Barre Syndrome, a neurological disorder.
- I have read the Influenza Vaccine Information Sheet and have had any questions answered to my satisfaction.
- I understand the benefits and risks of the flu shot, and ask that the flu shot be given to me (or to the person for whom I am authorized to make this request).
- I accept responsibility for seeking medical attention if a problem occurs after having been given this vaccine.
- I allow billing to my insurance, or have paid the full fee of the vaccine.

SIGNATURE _____ **DATE** _____

FOR OFFICE USE ONLY

	INFLUENZA		FLU MIST		PNEUMONIA
	DOSE 1	DOSE 2	DOSE 1	DOSE 2	
Date Administered					
Vaccine Manufacturer	Sanofi Pasteur	Sanofi Pasteur	Medimmune	Medimmune	
Lot Number	UH458AA HD UH468AB HD UT450AA UT473AB		501092P 501098P		0631AA
Site of Injection					
Signature of Vaccinator: _____					