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:** _____ **Age** _____

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

Please indicate method of payment below:

Medicare Number _____ **(Do not need Medicare Supplement)**

Title 19 Number/MCO _____

Insurance that pays for flu & pneumonia shots:

Policyholder: _____ **Birthdate** _____
Address _____
Phone _____ **SSN** _____ **Gender** _____
Employer _____ **Employer Phone** _____
Employer Address _____

Insurance Co. Name & Address _____
Policy # _____ **Group #** _____

Cash/ Check: Amount paid _____ **Check number** _____

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 vaccine 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

	High Dose Age 65 > 90662 (Q2039 Medicare only)	**Fluzone (private) (6 mos. +) 90686**	**Flulaval/ Fluarix VFC only** (6 mos +) **90686**	**FluMist 90672 (age 2-49 yrs) VFC/ Private**	**2nd dose**	**Pneumo 23 90732 PCV13 90670**
Date Administered						
Vaccine Manufacturer	**Sanofi Pasteur**	**Sanofi Pasteur**	**GSK**	**Medimmune**		**Merck/Pfizer**
Lot Number Expiration						
Site of Injection/ Signature						

IRIS _____ **Cerner** _____ **Medicare** _____ **State** _____ **VFC** _____