Davis County Health Department

FLU VACCINE ADMINISTRATION RECORD

Client Last Name	First Name	Middle	Date of Birth (mm/dd/yy)	Patient Age
Language	Race: ☐ White ☐ Asian ☐ Black ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander	Ethnicity ☐ Hispanic ☐ Non Hispanic		Gender ☐ Male ☐ Female
Address:		City	State	Zip Code
Phone #	Alternate Phone #	E-mail		
Primary Health Insurance:	Policy #	Insurance Policy Holder: (Exact Name as listed on Card)		
Secondary Health Insurance:	Policy #	Insurance Policy Holder: (Exact Name as listed on Card)		
Insurance Policy Holder Date of Birth (mm/dd/yy):	Relationship to Patient:	Home Address of Policy Holder if Different than Patient:		

By signing this form, I understand that Davis County Health Department expects payment at the time of service unless other billing arrangements have been made. **I understand that all charges incurred are my responsibility ______.** To bill my medical insurance, Davis County Health Department must have a copy of my insurance card or proof of coverage with all the necessary information to file a claim. I further understand the insurance cards are not kept on file. **If Davis County Health Department has a contract with my insurance company, only services covered by my plan will be paid. It is my responsibility to know what my plan covers and agree to pay any portion not covered. I understand that if Davis County Health Department does not have a contract with my insurance company, I am responsible for all charges incurred ________.**

By signing this form, I acknowledge having received the Davis County Health Department Notice of Privacy Practice (HIPPA). I further release Davis County Public Health Department from liability regarding immunization services rendered. I assume responsibility as the individual to receive the vaccine(s) or assume the responsibility as the individual authorized to make the request.

Signature Client/Parent/Guardian: ____________________________ **Today's Date:** ___/___/______ __
mm dd yyyy

Print Name ______________________________________ **Date of Birth (MM/DD/YY)** ___/_____/________

Screening Questionnaire - Please complete for the person to be vaccinated	NO	YES
Are you sick today?		
Do you have allergy to eggs, any component of the vaccine, or any **OTHER KNOWN ALLERGIES?** If yes, explain		
Have you ever had a serious reaction to the influenza vaccine in the past? Had wheezing or asthma in the past?		
Have you had Guillain-Barre Syndrome; Epilepsy or other Nervous System problems? If yes, explain:		
Have you received any vaccinations in the past 4 weeks?		
Females: Are you pregnant?		

TO BE COMPLETED BY THE VACCINE ADMINISTRATOR

Vaccine Type	Manufacturer Lot #/Exp Date	Site	Dose Route	Nurse Initials	VIS Date
HIGH DOSE Fluzone 65 yrs+ or FLUBLOK 50-64 yrs		__RD __LD	0.5mL IM		08/07/2015
MVD Fluzone/Flulaval QIV 3 – 64 yrs		__RD __LD	0.5mL IM		08/07/2015
Preservative Free Fluzone QIV 3-64 yrs.		__RD __LD	0.5mL IM		08/07/2015
PEDIATRIC Fluzone QIV 6-35 months		__RD __LD	0.25ml IM		08/07/2015
FLUMIST LAIIV 2-49 yrs		Nostril	0.2mL		08/07/2015
		__RD __LD	0.5mL IM		

PAYMENT SECTION (For office use)

Cash $	Credit $	Check #/$	VFC Eligible ☐	By

Updated (8/08/2018)