

**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 Black Alaskan/ Native American Asian Hawaiian / 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:		
<p>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. If the 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.</p> <p>My signature indicates that I have reviewed and read a copy of the Notice of Privacy Practice (HIPPA), and have had explained to me the Vaccine Information Statement (VIS) for each vaccine that I am requesting be given to the person named on this form. I further release the Davis county health department from any liability regarding immunization services rendered.</p>						
PRINT NAME : _____		SIGNATURE: _____		DATE: _____		
Relationship: Self Parent or Guardian					Staff Initials: _____	

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
Fluzone High Dose PF 65 yrs+ or Flublok High Dose PF 50 yrs+		__RD __LD	0.5ml IM		08/15/2019
Fluzone MVD 6 months & older		__RD __LD	0.5ml IM		08/15/2019
Fluzone/Flulaval PF 6 months & older		__RD __LD	0.5ml IM		08/15/2019
Flucelvax PF 4 yrs & older		__RD __LD	0.5ml IM		08/15/2019
Flumist LAIIV 2 yrs - 49 yrs		Nostril	0.2 ml		08/15/2019
		__RD __LD	0.5ml IM		

PAYMENT SECTION (For office use)

Cash \$	Credit \$	Check #/\$	VFC Eligible <input type="checkbox"/>	By
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