

**Clermont County Public Health
2017-2018 Inactivated Flu Vaccine Administration Form**

SECTION 1

NAME (LAST)	(FIRST)	MI	DATE OF BIRTH	AGE	GENDER (M/F)
ADDRESS		CITY	STATE	ZIP CODE	PHONE
PARENT/GUARDIAN NAME (IF UNDER 18 YEARS OF AGE)			GUARDIAN'S PHONE #		

SECTION 2

PLEASE ANSWER THE FOLLOWING QUESTIONS	YES	NO
Is the person to be vaccinated sick today?		
Does the person to be vaccinated have an allergy to eggs, latex, thimerosal or a component of the vaccine?		
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?		
Has the person to be vaccinated ever had Guillain-Barre' syndrome?		

SECTION 3

I give Clermont County Public Health (CCPH) permission to release the medical records of the above named person to their healthcare provider, school/employer, and the Ohio Department of Health Immunization Registry. I have received the Vaccine Information Statement (VIS Inactivated Influenza Vaccine) and the CCPH Notice of Privacy Practices. I understand that it is recommended to wait at the clinic site for 15 minutes following vaccination, and I had an opportunity to ask questions and discuss the vaccine with a medical professional. I understand the risks and benefits of the vaccine, and acknowledge the Clermont County Board of Health is not responsible or liable for any vaccine reaction that may occur. I am authorized to request vaccine administration. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature of person to receive vaccine or person authorized to make the request

Date

SECTION 4 – FOR OFFICE USE ONLY

PAYMENT <input type="checkbox"/> CASH <input type="checkbox"/> CHECK # _____ \$ Amount _____ <input type="checkbox"/> Credit Card	VFC ELIGIBLE (< 19 YEARS OF AGE) <input type="checkbox"/> YES (MEDICAID, NO HEALTH INSURANCE) <input type="checkbox"/> NO
MEDICARE NUMBER	MEDICAID NUMBER
	Check One: <input type="checkbox"/> Buckeye <input type="checkbox"/> CareSource <input type="checkbox"/> Molina <input type="checkbox"/> Ohio Medicaid <input type="checkbox"/> Paramount <input type="checkbox"/> UHC ComPl

DATE ADMINISTERED	SITE OF INJECTION <input type="checkbox"/> RD <input type="checkbox"/> LD <input type="checkbox"/> RT <input type="checkbox"/> LT	VACCINE DOSAGE <input type="checkbox"/> 0.25ML <input type="checkbox"/> 0.50ML
VACCINE LOT NUMBER	VACCINE MANUFACTURER <input type="checkbox"/> Sanofi Pasteur <input type="checkbox"/> Other _____	
SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR		