# INFLUENZA VACCINE
## ADMINISTRATION RECORD

I have read or have had explained to me the information in the Vaccine Information Statement about influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request.

| INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT) | | | |
|---|---|---|---|
| Name LAST: | FIRST: | | MIDDLE INITIAL: |
| Address: | Phone: | Birthdate: | M/F WT. Age: |
| City: | State: | ZIP: | County: |
| Allergies: | | | |
| Physician Name: | Address: | | |

The following questions will help us determine which vaccines may be given to you today. Please check the appropriate answer. If any question is unclear, please ask us to explain it.

| | Yes | No | Don't Know |
|---|---|---|---|
| 1. Are you sick today or do you currently have a fever? It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better. | ☐ | ☐ | ☐ |
| 2. Have you ever had a severe or life-threatening allergic reaction after a dose of flu vaccine, or have a sever allergy to any part of this vaccine? Most, but not all, types of flu vaccine contain a small amount of egg protein. | ☐ | ☐ | ☐ |
| 3. Have you ever had Guillain-Barré Syndrome (also called GBS)? Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor. | ☐ | ☐ | ☐ |
| 4. If patient is between the ages of 7 and 18, what is the patients's weight? _____lbs. | | | |

**FOR MEDICARE RECIPIENTS:** 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.

SEE ATTACHED COPY OF MEDICARE CARD IF MEDICARE ELIGIBLE

| | | |
|---|---|---|
| SIGNATURE AUTHORIZING VACCINATION; of person to receive vaccine or person authorized to make request (parent or legal guardian) for vaccination<br>X | | DATE: |
| Patient Signature above and Vaccinator signature below also indicates patient receipt of this year's Influenza Vaccine Information Statement on date signed. | VIS DATE: | CHRONIC ILLNESS<br>[ ] YES [ ] NO |

DO NOT WRITE BELOW THIS LINE (CLINIC/OFFICE USE ONLY)

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FOR CLINIC/OFFICE USE ONLY

| | | | | |
|---|---|---|---|---|
| PHARMACY/CLINIC NAME: | | | | |
| **55 South 23rd Street**<br>**Cambridge, OH 43725**<br>**740-432-3810** | **104 Plaza Drive**<br>**St. Clairsville, OH 43950**<br>**740-695-0274** | **4595 Central Avenue**<br>**Shadyside, OH 43947**<br>**740-676-2325** | **2200 June Parkway**<br>**S. Zanesville, OH 43701**<br>**740-450-7859** | **56130 National Rd.**<br>**Bridgeport, OH 43912**<br>**740-633-3368** |
| DATE VACCINE ADMINISTERED: | | | | |
| VACCINE NAME & MANUFACTURER: | Afluria (CSL) | Fluarix* or FluLaval* (GlaxoSmithKline) | Flucelvax or Fluvirin (Novartis) | |
| | Fluzone* or Fluzone High-Dose or Fluzone Intradermal (sanofi pasteur) | | FluMist** (MedImmune) | |
| | *Fluarix/FluLaval/Fluzone Trivalent or Quadrivalent; | | **FluMist Quadrivalent | |
| VACCINE LOT NUMBER & EXPIRATION DATE: | | | | |
| SITE OF INJECTION / NEEDLE GAUGE / LENGTH | L Arm R Arm / 25G 1in 25G 5/8in Other: | | | |
| STRENGTH/DOSE GIVEN & ROUTE Other Notes | 0.5mL/IM 0.2mL/intranasal 0.1mL/intradermal Notes: | | | |
| Other Medications Administered (e.g., epinephrine, etc.) | | | | |
| SIGNATURE / TITLE OF VACCINE ADMINISTRATOR: (Administering pharmacist OR pharmacy intern & supervising pharmacist) | | | | |
| PAYMENT SOURCE:<br>[] CASH [] CHECK [] * BILL MEDICARE OTHER _____<br>* IF MEDICARE ELIGIBLE THE MEDICARE CARD IS REQUIRED. | | | | |



**White - Pharmacy Copy Yellow- Physician Copy Pink - Patient Copy**