

EAST SIDE HEALTH DISTRICT FLU VACCINE ADMINISTRATION RECORD

(Please Circle one)

1. Is the person to be vaccinated sick today? YES or NO
2. Does the person to be vaccinated have an allergy to eggs or any medications? YES or NO
If Yes, please explain: _____
3. Has the person to vaccinated ever had a serious reaction to influenza vaccine in the past? YES or NO
If Yes, please explain: _____
4. Has the person to be vaccinated ever had Guillian-Barre syndrome? YES or NO
5. Is the person to be vaccinated pregnant? YES or NO
6. State any long term health problems/illness _____
Examples: asthma, diabetes, heart, kidney, lung disease, neurologic disease, HIV/AIDS, cancer

I acknowledge that I have received from East Side Health District a copy of the "Notice of Privacy Practices." I have read or have had explained to me the information about influenza and 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 to the person named below for whom I am authorized to make this request.

<i>Information about person to receive vaccine (Please Print in Ink and fill out completely)</i>		
First Name: _____	Middle Initial _____	Last Name: _____
Date of Birth: _____	Age: _____	Phone #: _____
Mailing Address: _____		
City: _____		Zip: _____
Signature of person to receive vaccine or person authorized to make the request (parent or guardian):		
X _____	Date: _____	

Do not write below this line
For Clinic/Office Use

Clinic/Office Address: _____ **ESHD** _____ **Date Given:** _____

Vaccine Manufacturer: _____ Lot #: _____

Site of Administration: _____ .50 mL Dose .25 mL Dose

1st Dose 2nd Dose or N/A

Signature of Vaccine Administrator and Title:

Amount Paid for Injection _____ Medicare Part B # only _____

Employee : _____ Public Aid (RIN)# : _____