INFLUENZA (VIS 8/15/19) VACCINE ADMINISTRATION FORM

I HAVE BEEN GIVEN A COPY AND HAVE READ, OR HAVE HAD EXPLAINED TO ME, THE INFORMATION ON THE "Vaccine Information Sheet" for INFLUENZA and the vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me or to the person for whom I am authorized to make the request.

Last Name First Name Middle Initial

Street Address City State Zip Code County

Date of Birth Age Telephone Number

Have you received services at the health department before? _____YES _____NO
Please Circle the Appropriate Response: (for statistical purposes)

Male	Single	White/Caucasian	Asian/Pacific Islander
Female	Married	Black/African American	Alaskan/Native American
	Widowed	Hispanic/Latino	

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you have Medicare, Medicaid or other insurance? _____YES _____NO
Are you **pregnant**? _____YES _____NO
Do you have **allergies to eggs** or any other food or medication? _____YES_____ NO
If yes, please list:_____
Are you ill now or do you have a chronic medical condition? _____YES_____ NO
If yes, please list:_____
Have you ever been diagnosed with **Guillian-Barre Syndrome**? _____YES_____ NO

Signature of Recipient or Parent/Guardian **Date**

FOR CLINIC USE ONLY

Vaccine Provider: **Seward County Health Department** **Clinic Site: 088**
103 W. 2nd Street
Liberal, Kansas 67901

Manufacturer_____
Lot #_____
Expiration Date_____
Circle one: Intranasal or IM Site_____
DOSAGE: 0.5ml or 0.25ml
Pneumococcal 23 0.5ml Site _____
Manufacturer _____
Lot # _____
Expiration Date: _____

Vaccine Administrator **Date**

TYPE OF PAYMENT

Credit Card:_____
Check #_____
Cash_____
Insurance Company: _____
Medicare/Medicaid #
_____