Clermont County Public Health

2020-2021 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; OR LEGAL GUARDIAN)	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 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

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SECTION 4 – FOR OFFICE USE ONLY

PAYMENT ☐ **CASH** ☐ **CHECK #_____ $ Amount** **_____**	**VFC ELIGIBLE** (< 19 YEARS OF AGE) ☐ **YES (MEDICAID, NO HEALTH INSURANCE)** ☐ **NO**
☐ **Credit Card**	**MEDICAID NUMBER**
MEDICARE NUMBER	**Check One:** ☐ Buckeye ☐ CareSource ☐ Molina ☐ Ohio Medicaid ☐ Paramount ☐ UHC Com Pl
PRIVATE INSURANCE TYPE	**PRIVATE INSURANCE BILLING #**

DATE ADMINISTERED	SITE OF INJECTION ☐ **RD** ☐ **LD** ☐ **RT** ☐ **LT**	VACCINE DOSAGE ☐ **0.25ML** ☐ **0.50ML**
VACCINE LOT NUMBER	**VACCINE MANUFACTURER** ☐ **Sanofi Pasteur** ☐ **Other _____**	
SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR		

Revised: 9/10/2020