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**IMMUNIZATION CONSENT AND RECORD**

CLINIC SITE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PATIENT AND INSURANCE/PAYMENT INFORMATION**  NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX (M)\_\_\_\_\_\_\_\_(F)\_\_\_\_\_\_\_\_\_  ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APT\_\_\_\_\_\_\_ CITY & STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PHONE (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **PATIENT SCREENING INFORMATION**  The following questions will help us determine which vaccines you may be given today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked.   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | Yes | No | Don’t Know | Comments: | | 1. Are you sick today? |  |  |  | | 2. Have you ever had a serious reaction to after receiving a vaccine? |  |  |  | | 3. Are you allergic to eggs, egg products or poultry? |  |  |  | | 4. Are you allergic to any medications, latex or Thimerosal(a vaccine preservative)? |  |  |  | | 5. Have you had a seizure, a brain or nervous system problem or history of  Guillain-Barre Syndrome? |  |  |  | | 6. For women: Are you pregnant or is there a chance you could become pregnant  during the next month? |  |  |  |   (PATIENT) Questions answered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (VACCINE ADMINISTRATOR) Responses Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contraindications present? Yes/No If Yes, explain: |

**PATIENT CONSENT**

* I have had a chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits and the risks and ask that the Seasonal Flu vaccine or injection be given to me or to the person named for whom I am authorized to make this request.
* I have received a copy of the Vaccine Information Statement (VIS) for the Seasonal Flu Vaccine that I will receive today. I have read or have had explained to me the information provided to me regarding the vaccine I will be receiving.
* I have received a copy of the Notice of Privacy Practices.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(TO BE COMPLETED BY NURSE)**

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| ***COMMERCIAL Flu and Administration Code***  \_\_\_\_\_\_\_\_\_ 90658 Fluvirin (Trivalent)  \_\_\_\_\_\_\_\_\_ 90688 Flulaval (Quadrivalent )  \_\_\_\_\_\_\_\_\_ 90653 Fluad ( 65 years and older)    \_\_\_\_\_\_\_\_\_ 90471 ADMINISTRATION, One vaccine |

**Vaccine Administration Record**

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| **Vaccine** | **Date Vaccine was Given** | **Site and Route** | **Manufacturer** | **Lot #** | **Date on VIS** | **Date VIS was given to patient** |
| **Influenza** |  |  |  |  | 8/7/2015 |  |

**Vaccine(s) administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_**