LORAIN COUNTY PUBLIC HEALTH INFLUENZA VACCINE ADMINISTRATION

Client Name: (Last) (First) (MI)		**Phone:**	( ) -
Address: (Street) (City) (State) (Zip)			
☐ Male ☐ Female	**Date of Birth:** / /	**Age:**	**Township, if applicable:**

How did you hear about this flu clinic? (check all that apply)

☐ **Newspaper** ☐ **Radio** ☐ **Website** ☐ **School/Work** ☐ **Family/Friend** ☐ **Facebook/Twitter** ☐ **Other:**

I have received a copy and have read or had read to me the information contained in the appropriate Vaccine Information Statement (VIS) about the vaccine(s) I am requesting. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) indicated on this record be given to me or the person named above for whom I am authorized to make this request. I have received a copy of the Lorain County Public Health (LCPH) Privacy Statement.

LCPH participates in the Ohio immunization registry known as Impact-SIIS. Today's record of immunization will be entered in Impact-SIIS and LCPH's electronic health record (EHR). This information is kept confidential and shared only with health care providers, your insurance company, and agencies for the sole purpose of protecting your health and the health of others. The information shared includes your name, birth date, types of vaccines, and the dates they were given.

In the event my insurance does not reimburse LCPH or my employer is not covering the fee for vaccine, I understand I am receiving the vaccine at no cost provided by the taxpayers through levy funding. If I do not have insurance, I understand I am receiving vaccine provided by the State of Ohio, and levy funding will pay for the administration fee.

I authorize LCPH to give information to the identified insurance carrier(s) for any and all payment activities.

Signature: _____ **Date:** _____

(Parent or guardian's signature if client is under 18 years of age)

Print Name: _____

FOR CLERICAL USE ONLY			
Please indicate form of insurance and payment below (circle one):			
Medicaid **Private Insurance** **Medicare** **None**	**Check**	**Cash**	**No Charge**
ID Copied? ☐ **Yes** ☐ **No**	**Clinic Location:**		

FOR NURSING USE ONLY					
Vaccine Lot # and Expiration Date:					
Site/Route (circle one):	**RD/IM**	**LD/IM**	**RVL/IM**	**LVL/IM**	**Nasal**
Influenza VIS (8/7/2015) given: ☐					
Signature of Vaccine Administrator:			**Date:**		