Print Form

LORAIN COUNTY GENERAL HEALTH DISTRICT 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 General Health District (LCGHD) Privacy Statement.

LCGHD participates in the Ohio immunization registry known as Impact-SIIS. Today's record of immunization will be entered in Impact-SIIS and LCGHD'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 LCGHD 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.

Signature: _____ **Date:** _____

(Parent or guardian's signature if client 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 (circle one):	**RD**	**LD**	**RVL**	**LVL**	**Route: IM**
Influenza VIS (8/7/2015) given: ☐					
Signature of Vaccine Administrator:			**Date:**		

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

patient name _____

date of birth ____/____/____
month day year

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to a component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

form completed by _____ date _____

form reviewed by _____ date _____

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota · 651-647-9009 · www.immunize.org · www.vaccineinformation.org

www.immunize.org/catg.d/p4066.pdf · Item #P4066 (9/16)