

# Vaccine Administration Form

Name: Last		First	Middle Initial	Birth Date	Age
Mailing Address		City	County	State	Zip
Phone#		Race (circle one) Asian Black Hispanic White American Indian Alaskan Native Multi-Race Other			Sex: M F
Primary Insurance Company Name		Member/Subscriber ID #		Member Group #	
Primary Insured Name		Primary Insured Date of Birth		Primary Insured Relationship to Patient Self Dependant	

**Patient Medical Information:**

	Yes	No
1. Is client sick today/been ill with a fever in the last 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does client have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has client had a serious reaction after receiving a vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has client received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has client had a seizure; or had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does client have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does client have a long-term health problem with heart disease, lung disease, asthma, kidney disease, Metabolic disease (e.g., diabetes), anemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
8. In the past year, has client received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does client take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatment?	<input type="checkbox"/>	<input type="checkbox"/>
10. Is client pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>
11. Does client provide care for infants or newborns (age 12 months & under)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does client take medication such as Humira, Enbrel, Remicade, Methotrexate?	<input type="checkbox"/>	<input type="checkbox"/>

**Consent for treatment:** I have received a copy of information about the disease(s) and vaccine(s) indicated below. I have read or have had explained to me this information. I have had a chance to ask questions that were answered to my satisfaction. 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 to the person above for whom I am authorized to make this request. I have been advised to wait 15 minutes after the injection to monitor for signs & symptoms of an allergic reaction. I give permission to the Sidney-Shelby County Health Department to release/receive the immunization records of the above named client to any doctor, school and/or agency when requested. I also acknowledge receipt of the Shelby County Health Department's Notice of Health Information Privacy Practices.

**Signature of person to receive vaccine or person authorized to make the request (parent or guardian):**  
 X \_\_\_\_\_ Relationship to Client: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\* HEALTH DEPARTMENT STAFF USE ONLY \*\*\*\*\*

**Payment/Insurance Information:** 1) Is covered by Medicaid 2) Has health insurance that covers immunizations for this visit  
 3) Has health insurance that does not cover immunizations or has limited coverage 4) Does not have health insurance

TOTAL CHARGE: \$ \_\_\_\_\_ Initials \_\_\_\_\_ Receipt # \_\_\_\_\_  HIPAA  VIS

- Vaccines**
- Initial vaccines that your child can receive
- Meningitis (Required)
  - Tdap (Required)
  - Hepatitis A
  - HPV
  - 
  -

**Vaccine Administration Information:**

Date Given	Manufacturer	Lot Number	Site	Route	Administered By	Time
			LA RA LT RT	PO ID IM SQ		
			LA RA LT RT	PO ID IM SQ		
			LA RA LT RT	PO ID IM SQ		
			LA RA LT RT	PO ID IM SQ		
			LA RA LT RT	PO ID IM SQ		