Vaccine Administration Form

Name: Last	First	Middle Initial	Birth Date	Age
Mailing Address	City	County	State	Zip
Phone #	Would you like to receive Email/Text Yes No	Race (circle one) Asian Black Hispanic White American Indian Alaskan Native Multi-Race Other		Sex: M F
School/Daycare Client Attending	Parent/Guardian Email	Person Responsible for Insurance Coverage Name: Birth Date:		

Patient Medical Information:

		Yes	No
1.	Is client sick today/been ill with a fever in the last 24 hours?	❑	❑
2.	Does client have allergies to medications, food, a vaccine component, or latex?	❑	❑
3.	Has client had a serious reaction after receiving a vaccine?	❑	❑
4.	Has client received vaccinations in the past 4 weeks?	❑	❑
5.	Has client had a seizure; or had brain or other nervous system problems?	❑	❑
6.	Does client have cancer, leukemia, HIV/AIDS, or any other immune system problem?	❑	❑
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?	❑	❑
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?	❑	❑
9.	Does client take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatment?	❑	❑
10.	Is client pregnant or is there a chance she could become pregnant during the next month?	❑	❑
11.	Does client provide care for infants or newborns (age 12 months & under)?	❑	❑
12.	Does client take medication such as Humira, Enbrel, Remicade, Methotrexate?	❑	❑
For Children under 2 years of age:			
13.	In the last 12 months, has a healthcare provider told you that your child had wheezing or asthma?	❑	❑
14.	Have you ever been told your child has intussusception (emergency bowel surgery)?	❑	❑
15.	This client would like referral to: **(please circle)** **1)** WIC **2)** Help Me Grow **3)** Well Child Clinic **4)** BCMH		

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: _________

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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

Primary Insurance Name/ID: ____________________________ Secondary Insurance Name/ID: ______________________________

TOTAL CHARGE: $ __________ Initials ______ Receipt # _______________ ❑ HIPAA ❑ VIS

Vaccine Administration Information: **Return Date & Time:** ____________________________________

Private	VFC/ODH	VaxCare	Vaccine	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		
❑	❑	❑					LA RA LT RT	PO ID IM SQ		