TALBOT COUNTY HEALTH DEPARTMENT

FLU SHOT VACCINE CONSENT & ADMINISTRATION RECORD

******** PLEASE PRINT INFORMATION ABOUT THE PERSON TO RECEIVE VACCINE **********				
NAME: Last First Middle Initial		**Birth Date (mm/dd/yy)**	**AGE:**	
ADDRESS: Number & Street (Apt #)	**City**	**County**	**State**	**Zip**
SEX: M / F	**Daytime Phone #: _____-_____-_____**			

********** PLEASE CIRCLE YES OR NO FOR EACH QUESTION. **********

QUESTIONS 1-4 DETERMINE IF VACCINE CAN BE GIVEN:	
1. Are you moderately or severely ill today WITH A FEVER?	**YES NO**
2. Have you ever had SEVERE/UNUSUAL REACTION after receiving any vaccine?	**YES NO**
Describe the reaction: _____	
3. Did the reaction involve PARALYSIS and/or occur within 6 wks after having flu vaccine?	**YES NO**
4. Have you ever had SEVERE ALLERGIC REACTION TO EGGS?	**YES NO**
QUESTIONS 5-10 DETERMINE IF SPECIAL PRECAUTIONS NEED TO BE TAKEN:	
5. Do you have diabetes or other metabolic disorder, or diseases of the lungs, heart, kidneys, liver, blood or nervous system? _____	**YES NO**
6. Do you have a weak immune system (from cancer, HIV or medicines containing steroids or for treating cancer)? _____	**YES NO**
7. Do you have any bleeding disorders or take aspirin or other anticoagulants every day?	**YES NO**
8. Are you pregnant at this time?	**YES NO**
9. List all your current medications. _____	
10. List all your allergies. _____	

********** PLEASE READ AND SIGN CONSENT ON THE LINE BELOW.**********

"I have read or had explained to me the information in the Vaccine Information Statement(s) (VIS) for influenza and/or pneumococcal vaccines. 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 they be given to me or to the person named above for whom I am authorized to make this request."

"If not paying by cash today, I authorize the Talbot County Health Department to bill my insurance company (Medicare or Medical Assistance only) for services given to the person named above."

"I have been given or offered a copy of the Notice of Privacy Policies (HIPAA) form."

X_____ Relationship: _____Today's Date: _____

(Signature of person receiving or consenting to the vaccination)

FOR CLINIC USE ONLY BELOW THIS LINE

Vaccine given:	**INFLUENZA**	**High Dose Influenza**
Date of VIS:	**8/06/2021**	**08/06/2021**
Route of Administration: (Circle one)	**IM: LA RA**	**IM: RA LA**
Vaccine Manufacturer: (Circle one)	**GSK Fluarix B94B3** **Flucelvax 370648 VFC**	**Sanofi Pasteur Fluzone UT80720A**
Signature & Title of Vaccine Administrator:		**Today's Date:**