|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sussex County Health Unit | Seaford Public Health | Milford Health Unit | Kent County Health Unit | Hudson S.S.C. |
| 544 S. Bedford St. | 350 Virginia Ave | 253 NE Front St | 805 River Rd. | 501 Ogletown Rd. |
| Georgetown, DE 19947 | Seaford, DE 19973 | Milford, DE 19963 | Dover, DE 19901 | Newark, DE 19711 |

, .

## Influenza Vaccination Administration Record

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient’s last name:** | | | | | | | | **First:** | | | | | **Middle:** | | | **Gender:** |
|  | | | |  | | | | | | |  | | | | | M  F  Trans  Other |
| **Street address:** | | | | | | | | | | | | | | | | **Phone:** |
|  | | | | | | | | | | | | | | | |  |
| **City:** | | | | | | | | | | | | | | **State:** | | **ZIP Code:** |
|  | | | | | | | | | | | | | |  | |  |
| **Date of Birth:** | | | | | | **Age:** | | | | | | | | **Hispanic Ethnicity:** | | |
|  | | | mm/dd/yyyy | | |  | | | | | | | | Yes No | | |
| **Race** (Check all that apply): | | | | | White | | | | Black | Asian | | Native Hawaiian/Pacific Islander | | | | |
|  |  | | | | American Indian/Alaska Native | | | | | | | | | | | |
| **Insurance:** | | None Medicare  Medicaid DHCP\* Other | | | | | | | | | | | | |  | |
| **If insured by Medicaid MCI #** | | | | | | | **MCO (if insured by Medicaid):** | | | | | | | | | |
|  | | | | | | | Highmark  DSP  United Healthcare  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medical Screening** | **No** | **Yes** | **Clinician’s Note** |
| Is the person to be vaccinated pregnant? |  |  |  |
| Is the person to be vaccinated sick today? |  |  |  |
| Has the person to be vaccinated ever had a serious allergic reaction to:   * Influenza vaccine? * Eggs, egg proteins? * Natural rubber latex; or other substances? \_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Has the person to be vaccinated ever had Guillain-Barré syndrome? |  |  |  |

My signature (below) means that I have been given a copy of the appropriate Vaccine Information Statement (VIS) and have read, or have had explained to me, information about the disease and the vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits as set forth in the VIS I was given and I ask that the vaccine be given. Also, by signing below I hereby give my consent for DPH to bill my insurance based on eligibility for the vaccine received.

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signer’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Patient**  **Parent** **Guardian**

**Print Clearly**

*Do not write below this line. For Clinician use only.*

**NHS \_\_\_ SHS \_\_\_ Clinic Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Presentation/Route** | **Dose** | **Site** | | | **VIS Date** | **VIS Given Date** |
| **Quad W/Pres/IM \_\_\_**  **Quad Inj. P-Free/IM \_\_\_**  **Ped. Quad. P-Free/IM\_\_\_** | **0.25ml \_\_\_ 0.5ml \_\_\_** | **RA \_\_\_ RT \_\_\_ LA \_\_\_ LT \_\_\_** | | | 8/07/2015 |  |
| **Vaccination Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**  MM/DD/YYYY | | **Manufacturer:** Sanofi, GSK  circle one | **Lot #**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

**Clinician’s Signature:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_License Title** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **VFC** –Child is under age 19 and  **[*Use FED*]**  Child isenrolled in Medicaid **or**  Child is uninsured **or** Child is American Indian or Native Alaskan | Child isenrolled in **Delaware Healthy Children’s Program (DHCP\*) [*Use FED*]**  None of the above (child or adult)  **[*Use STATE*]**  Doc # 35-05-20/17/09/07 |