|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 |

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## 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 |