LOGAN COUNTY INFLUENZA VACCINE ADMINISTRATION RECORD

PATIENT INFORMATION

Name _____ **Date of Birth**_____

Mailing Address _____ **City** _____ **State** ____

Zip Code _____ **Phone Number**_____ **Gender: Male Female**

INSURANCE INFORMATION

❑ **My insurance** _____ **(Must provide current copy of card)**

❑ **I am paying by cash or check#**_____ **(Please circle one)**

HEALTH SCREENING	(Circle One)
Is the person to be vaccinated sick today?	Yes or No
Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	Yes or No
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	Yes or No
Has the person to be vaccinated ever had Guillain-Barre Syndrome (GBS)?	Yes or No
Is the person to be vaccinated younger than age 2 years or older than age 49 years?	Yes or No
Does the person to be vaccinated have a long-term health problem?	Yes or No
If the person to be vaccinated is a child, aged 2-4 years, has a healthcare provider them you the child had wheezing or asthma?	Yes or No
Does the person to be vaccinated have CSF, cochlear implants and/or an immunocompromising condition?	Yes or No
Is the person to be vaccinated currently taking influenza antiviral medications, or have they taken any within the past 3 weeks?	Yes or No
Is the person to be vaccinated a child or teen age 6 months thru 17 years and receiving aspiring-or salicylate-containing medicine?	Yes or No
Is the person to be vaccinated pregnant or could they become pregnant in the next month?	Yes or No
Does the person to be vaccinated live with or have close contact with a person whose immune system is severely compromised and who must be in protective isolation?	Yes or No
Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	Yes or No

I have been offered a copy of the "Vaccine Information Statement" and ask that the Influenza Vaccine be given to me or to the person named for whom I am authorized to make this request. The Logan County Health Department may release my medical information to my insurance provider, as necessary to receive payment. I understand any amount not covered by insurance is my responsibility. LCHD participates in electronic health information for billing and immunization registry purposes. For a notice of privacy practices patients may request a copy from LCHD.

Recipient/Parent/Guardian Signature _____ Date_____

**************************CLINICAL USE ONLY**************************		
Vaccine: Influenza Dx: Z23 CPT: 90656 90662 90660 90673 VIS: 8/6/2021	Inj. Site: L R Delt / Vas Lat Nasal	**2024/25 Influenza Season**
Administered by:	❑ Cash or Check #_____ ❑ Insurance card copied	Date:

8/21/24