Clinton County Health District

Pamela Walker-Bauer, MPH, RS, Health Commissioner
Steven Englender MD, MPH, Medical Advisor
111 S Nelson Ave Suite 1 Wilmington, Ohio 45177 Phone: (937)382-3829
Fax: (937)382-7027 Email : info@clincohd.com

INFLUENZA VACCINE ADMINISTRATION RECORD

Date of Service: _____ **Print Patient Name:** _____ **Sex:** _____

Mailing Address: _____ **City:** _____

ZIP _____ **Phone:** _____ **Date of Birth** _____

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Payment Method: **Insurance** **Medicare** **Medicaid** **Self-Pay** **Business**

Insurance Name, ID and Group #:

_____

Policy Holder and Date of Birth _____

Are you ill today?	Yes	No
Have you received a flu shot before?	Yes	No
Did you have a severe reaction following the shot?	Yes	No
Are you allergic to eggs?	Yes	No
Have you ever been diagnosed with Guillian-Barre Syndrome?	Yes	No

I authorize Clinton County Health District to release service related to me regarding the above mentioned person to third party payers and/or other health practitioners and to bill for services rendered to me. I have read or have had explained to me the Vaccine Information Sheet about influenza and the influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the risks and benefits of influenza vaccine and request that the vaccine be administered to me or to the person named above for whom I am authorized to make this request. I hereby acknowledge that a copy of the Clinton County Health Department Notice of Privacy Practices has been available to me. I understand this document provides information on how my health information may be used or disclosed by the Clinton County Health Department and my rights with respect to my health information.

For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the Clinton County Health Department.

I grant permission for this record to be released to medical providers, health departments, schools, day-care centers, and other as is necessary. I attest that all information on this form is accurate and I am responsible for all costs incurred at the time of each appointment services are rendered with the signature provided below.

X_____ _____

Signature of person to receive vaccine or authorized representative Date

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FOR OFFICE USE ONLY

Date Administered: _____ VIS Date: 8/6/2021

Lot Number: **Fluzone** **High Dose** **Flublok**

Site of Injection: RD LD RT LT Vaccine Administrator: _____

Revised 9/22