Clinton County Health District

Pamela Walker-Bauer, MPH, RS, Health Commissioner
Terry Kerr Holten MD, Medical Director
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:** ____________________________________
Mailing Address: ___________________________________ **City:** ____________________________________
Phone # _____________________ **Zip Code:** _____________ **Date of Birth** _________________ **Sex:** _________
****

Payment Method:
__Client __Insurance __Self-Pay __Medicare __Medicaid (VFC)
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
Have you had close contact with anyone with confirmed or probable Covid-19?	Yes	No
Have you or someone in your household had symptoms (fever, coughing, shortness of breath, etc.) in the past 14 days or been asked to quarantine or isolate at home?	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

FOR OFFICE USE ONLY

Date Administered: _____________ Vaccine Manufacture: SP GSK VIS Date 8/15/2019

Lot Number: **Fluzone** **High Dose** **Flublok** **Fluarix (317)**

Fluzone	High Dose	Flublok	Fluarix (317)
UJ705AA	UJ764AC	UJ725AA	BM9ZY
UJ712AC			

Site of Injection: RT LT RD LD

Vaccine Administrator: MW EM CW DP JS PD HH **PRIVATE BUSINESS SELF-PAY**

"The Clinton County Health District strives to keep our community healthy, educated and safe."
Equal Opportunity Employer-Provider

Revised 9/8/2021