Carroll County Health Department
P.O. Box 98
Carrollton, OH 44615
330-627-4866

INFLUENZA VACCINE ADMINISTRATION RECORD

Name. Birth Date: Age: Sex:

Address: City:

State: Zip: Phone: SS#

PLEASE ANSWER THE FOLLOWING QUESTION:

Are you sick today?	_____ Yes	______No
Are you allergic to eggs or an influenza vaccine component?	_____ Yes	______No
Do you have a latex allergy?	_____ Yes	______No
Have you had an allergic reaction to medications, food, or any vaccines?	_____ Yes	______No

PLACE A CHECK OR INITIAL BESIDE EACH OF THE FOLLOWING STATEMENTS:

_____ I have received a copy of the influenza vaccine infromation sheet.
_____ To the best of my knowledge, I understand the benefits and/or risks of the influenza vaccine.
_____ I have had a chance to ask questions about the vaccine that were answered to my satisfaction.
_____ I request to receive the influenza vaccine, or request the vaccine be given to the above-named individual for whom I am authorized by law to make said request.
_____ I have received and/or have explained to me the Health Departments Notice of Privacy Practices Summary which explains the policies concerning my personal health information.

I authorize the Carroll County Health Department (HD) to release to the below-named insurance company and medical or other information required to process a claim for benefits.
I understand that the HD will accept assignment of any claim and my signature below authorizes said intermediary to pay benefits on my behalf, directly to the HD.
I understand that any information so released will be treated as confidential by the HD, in accordance with the HD's HIPPA policies.

Signature of person receiving vaccine or person authorized to make the request (parent/guardian):

X____ Date:____________________

CHECK THE INSURANCE COVERAGE BELOW. IF THE INFORMATION IS INCORRECT, HAVE INSURANCE CARD OUT READY FOR THE CLERK TO PROCESS.

TO BE COMPLETED BY HD PERSONNEL: Medicaid: Buckeye Caresource Molina Paramount United Health Care (Community Plan)
Fee:
Cash________ Check________ Insurance: Anthem Aultcare Cigna Summa Medical Mutual ____________
United Health Care Ohio Health Choice
Medicare

Clinic Site: Injection Site:
LD RD Intranasal
LT RT

IDC: CPT/CPCD Codes:
Vaccine Manufacturer:
Lot #

Nurses Signature:

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