2017-2018 VACCINE ADMINISTRATION RECORD

"I have read or have had explained to me the information in this pamphlet about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request."

MEDICAID #: _____ MEDICARE #:_____

Please **print** and provide **all information** highlighted below.

NAME: _____ circle M or F

BIRTH DATE: _____ AGE: _____

ADDRESS: _____

CITY: _____ STATE_____ ZIP CODE_____

I ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF THE **"NOTICE OF PRIVACY PRACTICE, POLICY AND PROCEDURE"** AND GIVEN THE OPPORTUNITY TO READ THE NOTICE.

* IF YOU ARE SUBMITTING ANY OTHER TYPE OF INSURANCE AND IT GOES TOWARD YOUR DEDUCTABLE OR YOUR POLICY DOES NOT COVER THE FLU VACCINE, YOU WILL BE SENT A BILL AND BE EXPECTED TO PAY.

SIGNATURE: _____

DATE: _____

CLINIC/OFFICE USE ONLY

CLINIC ADDRESS: WINNEBAGO COUNTY PUBLIC HEALTH
216 SOUTH 4th Street
FOREST CITY IOWA 50436

DATE VACCINE ADMINISTERED :_____(L) (R) DELTOID

VACCINE AND LOT NUMBER: _____

SIGNATURE/TITLE VACCINE ADMINISTRATOR:

_____

Updated 8/22/2016