Patient Label

Flu Vaccine Administration Form
6 months and older

Recipient Full Name: _____**Date of Birth** ____/_____/_____

Home Phone Number: _____**Mobile Phone Number:** _____

Mailing Address: _____**City:** _____

Zip Code: _____ **County:** _____**State:** _____

Mother's Maiden Name: _____ (This is identifying information on your record in the North Carolina Immunization Registry and is confidential.)

Recipient Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown

Recipient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Recipient Gender: ☐ Male ☐ Female ☐ Other ☐ I do not want to specify

Preferred Language: ☐ English ☐ Spanish ☐ Other ☐ Decline to state

Check (√) Primary Insurance Type:

Private Insurance: ☐ Aetna ☐ BCBS ☐Cigna ☐ Health Choice ☐ Tricare ☐ UHC

Medicare: ☐ Regular Medicare ☐Aetna Medicare ☐ BCBS Medicare ☐UHC Medicare ☐ Humana

Medicaid: ☐ AmeriHealth ☐ Carolina Complete ☐ Healthy Blue ☐ UHC Community ☐ WellCare ☐ Family Planning Medicaid ☐ Regular Medicaid

Other: _____

☐ No insurance Amount paid: _____

_____ **I certify that I am**: (a) at least 18 years of age (b) the legal guardian of the patient. I voluntarily give my permission to receive the influenza vaccine.

I understand that my signature will serve as consent for vaccination, filing insurance/Medicaid claims and authorizing payment of benefits to the licensed healthcare provider for services rendered.

Recipient Signature _____

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you (or your child) inactivated injectable influenza vaccine today. If you answer "yes" to any question, it does not mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

PREVACCINATION CHECKLIST FOR FLU VACCINE	Yes	No	Don't Know
1. Are you feeling sick today			
2. Do you have any allergies? If "yes" please list below:			
3. Do you have a severe allergy to eggs or to a component of the vaccine? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing)*			
4. Have you ever had a serious reaction to influenza vaccine in the past?			
5. Have you ever had Guillain-Barré syndrome?			

OFFICE USE ONLY (VACCINE ADMINISTRATION INFORMATION)

FLU VACCINE

Vaccine Lot # and Expiration Date:

Administration Date: _____

Site of Injection: ☐ Left Deltoid ☐ Right Deltoid ☐Other_____

Vaccine administered by (Print Name) _____ **Signature**_____

Vaccination Site: BCHS **Other:** _____ ☐ Contract/Volunteer Staff

☐ Supervised by Stacie Holmes, RN

CureMD

Demo/Ins_____ (Init) **NCIR _____ (Init)** **Billed _____(Init)**

Date _____ **Date _____** **Date _____**

CureMD Account #: _____ **Paid _____**