Ontario School District

Richland Public Health
555 Lexington Ave
Mansfield, OH 44907
419-774-4540

SEASONAL INFLUENZA(Flu) VACCINE ADMINISTRATION RECORD

Name:		**Birth Date: / /**	**Age:**	**Sex:**
Address:	**Phone:**	**Race:**		
City:	**State: OH**	**Zip:**	**Township:**	

PLEASE ANSWER THE FOLLOWING QUESTIONS:	**YES**	**NO**
Is the person to be vaccinated sick today?		
Is the person to be vaccinated allergic to eggs? Medicines? Food? Latex? Any Vaccines? (please circle)		
Has the person to be vaccinated ever had Guillian-Barre' syndrome?		
Has the person to be vaccinated ever had a serious reaction after receiving a vaccination? Flu Mist?		
Has the person being vaccinated ever received an influenza(Flu) shot before?		
For Women Only: Are you pregnant or is there a chance you could become pregnant?		

FOR FLU MIST ONLY

Is the person to be vaccinated a child age 2 through 4 years with a history of recurrent wheezing?		
Does the person to be vaccinated have a long-term health problem or a weakened immune system?		
Is the person to be vaccinated receiving aspirin therapy or aspirin-containing therapy?		
Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severly compromised and who must be in a protective environment (such as in a hospital room with reverse air flow)?		
Has the person to be vaccinated received any other vaccination or antiviral in the past 4 weeks?		

I have received a copy of the influenza or flu mist vaccine information sheet. I had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I hereby consent that the local Health Department in which I received the vaccination can bill my insurance, if applicable. I understand I am financially responsible for any fees not covered by my insurance company. I authorize the release of this record to the Ohio Department of Health Immunization Program. I have received or been offered the Health Department's Notice of Health Information Privacy Practice and give permission to release my immunization record to my doctor or agency/school.

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 AND READY FOR THE CLERK TO PROCESS.

TO BE COMPLETED BY HD PERSONNEL:

Clinic Site:	**Injection Site:** LD RD LT RT Intranasal	**Vaccine Manufacturer & Lot #**	**Nurse's Signature**

Live VIS date 08/07/2015
Inactivated VIS date 08/07/2015