

Section 1 – PLEASE PRINT LEGIBLY (information for person being immunized).

LEGAL Name (Last, First, MI) Date of Birth Age Gender (M/F) Address City State Zip Code Phone Email Address

Section 2 - INSURANCE INFORMATION (ALL must be the Primary Insurance Coverage) Complete PARTS A and B.

PART A: Check primary insurance: Medicare/RR Medicare BCBS Coventry/Aetna PART B: Complete insurance information: Policy Holders Name DOB Policy ID Number Policy Holder Last 4 of SSN Relationship to insurance holder: Self Child Spouse Partner

Section 3 - Please select Yes or No in response to the following questions.

- 1. Sick or have a fever? Yes No
2. Have an allergy to eggs, latex, aluminum, yeast, thimerosal, Neomycin, Gentamicin\*, Arginine\*, gelatin\*?... Yes No
3. Had a serious reaction to a previous dose of any vaccine?... Yes No
4. Have any neurological problems, seizures, central nervous system disorders, Guillain-Barre'?... Yes No
5. Pregnant or planning to be in the next 4 weeks?... Yes No
\*6. Have any chronic health problems, asthma, diabetes, heart or lung disease? Yes No
\*7. Have cancer, AIDS, other immune problems, or live with someone who does? Yes No
\*8. Take cortisone, prednisone, any other steroids, chemotherapy or get radiation therapy? Yes No
\*9. Had any other vaccines in the last 4 weeks? Yes No

CONSENT: I acknowledge that the medical information provided above is correct. I have been offered a paper copy or have been able to access an electronic copy of the Notice of Privacy Practices and Vaccine Information Statement, understood the risks/benefits and request that the vaccine be given to me or the person named for whom I am authorized to make this request.

Individual OR Parent/Guardian Signature: Date:

Influenza Vaccine/Route: Dose: Site: Lot #:
FluLaval - IM 0.25mL (6-35mnths) OR LD RD
Fluzone - IM, Pres. Free 0.5mL Other:
Fluarix - IM
FluMist - IN
Vaccine Name/Dose and Route: Site: Lot #(s):
Boostrix 0.5mL IM (>= 10 years) LD RD
Energix-B 1.0mL IM (>= 20 years) LD RD
Havrix 1.0mL IM (>= 19 years) LD RD
Nurse Signature: Date:

Fee:
Cash
Check#
CC
Bill Employer
BCBS
Coventry/Aetna
Medicare
(Circle one):
VNA employee/
board member/
volunteer