INFLUENZA VACCINE ADMINISTRATION RECORD

Information About Person to Receive Vaccine (Please print)

Name: _____
Last First Middle Initial

Male/Female (please circle) **Birthdate:** _____ **Age:** _____

Address: Street: _____

City: _____ **State:** _____ **County:** _____

Zip:_____ **Phone Number:** _____

I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

Signature of person to receive vaccine or person authorized to make the request (parent or Guardian) and authorization to release this information to Medicare Part B/Medicaid/Insurance to process this claim.

_____ Date: _____
Signature

* *

************FOR CLINIC/OFFICE USE************
Additional Information Needed for Electronic Flu Filing

Medicare Health Insurance Number: _____

Medicaid Number: _____

Other: _____

Vaccine	VIS Date	Body Route	Body Site	Lot/Manufacturer
Influenza	8/7/15	IM	LD/RD	**UI640AB/SP**

Signature/Title of Vaccine Administrator:_____Date: _____