Form of Payment:

INFLUENZA VACCINE ADMINISTRATION RECORD FOR ADULT RECIPIENT

"I have read or have had explained to me the informational sheet about the influenza and the 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."

***PLEASE PRINT**

Name: _____ Last _____ First _____ M.I.	**Sex:** (circle one) **Male** **Female**

Date of Birth: _____/_____/_____	**Age:**	**Phone Number:** ( ) -	**Doctor's Name:**

Address: _____ Street _____ City _____ County _____ State _____ Zip

Allergy to Eggs? ☐ Yes ☐ No	**Is the recipient pregnant?** ☐ Yes ☐ No

Signature of person to receive vaccine or authorized to make the request: X _____ (Recipient *or* Parent/Legal Guardian)	**Date:** _____/_____/_____

Please Note: In the event of non-payment by Medicare, Medicaid, or your Employer, client served or guardian will be held responsible for the payment and will receive such statement/invoice.

Initials:_____

Medicare Recipients, please include:

***MediCARE* Card #:** _____

Medicaid Recipients/AllKids, please include:

***Recipient* #:** _____

For Clinic Use Only

Clinic or Office Address: LCDPH ☐ HOPE ☐ OTHER _____

Date Vaccine Administered: _____/_____/2010

Vaccine Manufacturer: **Fluzone** **Flulaval**

Vaccine Lot Number: **U3570CA** **AFLLA603AA**

Site of Injection: R Arm ☐ L Arm ☐ R Leg ☐ L Leg ☐

Signature and Title of Vaccine Administrator: _____