**LOCATION: Drive Thru Front of Hospital for Adults 2020**

**OFF‑SITE INACTIVE FLU VACCINE ADMINISTRATION RECORD**

# 2020-21

**I have read or have had read to me the VACCINE INFORMATION STATEMENT for the flu vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine listed below be given to me or to the person named below for whom I am authorized to make this request. I have completed and signed the Screening Questionnaire below for influenza vaccine. I UNDERSTAND AND HAVE BEEN GIVEN A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR\_Memorial Hospital.**

**I acknowledge I have been advised to remain in a designated area for at least 15 minutes after receiving the vaccine for observation of possible reaction. PLEASE INITIAL HERE. \_\_\_\_\_\_\_\_\_**

**Insurance:** We are now able to bill some insurance companies for immunization services. When you provide us with your insurance information, we will make every attempt to bill your insurance company. If the service is not covered or is denied, you will be mailed a bill along with a copy of the Explanation of Benefits (EOB). At that time, you will be expected to make payment for the service you received. By initialing here \_\_\_\_\_\_\_ you agree to pay for service or balance of the service after insurance payment.

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| **PATIENT INFORMATION (PLEASE PRINT)** | | |
| **NAME:** Last First MI | | **DOB:** |
| **ADDRESS:**  **CITY/ STATE/ZIP CODE:** | | **RACE: (circle one)**  **Black White Other (Specify)\_\_\_\_\_\_\_\_\_\_**  **SEX: M F Hispanic: Y N** |
| **ALLERGIES:** | | **PHONE NUMBER:** |
| METHOD OF PAYMENT**: Cash, Check, Medicaid, Medicare, Blue Cross/Blue Shield, Aetna/Coventry, Cigna, United Healthcare? Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  For Medicare Beneficiaries with part B: By signing this form you authorize the release of any medical or other information necessary to process this claim. You also request payment of government benefits either to yourself or the party who accepts assignment. You authorize payment of medical benefits to Memorial Hospital for services described. | | |
| **Screening:** The following questions will help us determine if there is any reason we should not give you or your child a vaccination today. If you answer “yes” to any question, it does not necessarily 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.  **1. Is the person to be vaccinated sick today?** **YES NO**  **EXPLAIN IF YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **2. Does the person to be vaccinated have an egg allergy or any life-threatening allergies?** **YES NO**  **EXPLAIN IF YES** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? YES NO**  **EXPLAIN IF YES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  4. **Has the person to be vaccinated ever had Guillain-Barré syndrome?** **YES NO**  **EXPLAIN IF YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  FOR CLINIC USE ONLY: | | |
| Vaccine Given: INFLUENZA  VIS Date: 8/15/2019  Date Vaccinated: 11/16/2020  Manufacturer :Seqirus: Afluria (Circle Lot Number Given)  Lot# P100245061 Lot #P100255594  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 11/16/2020  PATIENT/PARENT SIGNATURE DATE  REV 9/9/20 | Site of Injection: (circle site used)  IM – Left Deltoid Right Deltoid    11/16/2020  ADMINISTERED BY DATE | |