

VACCINE ADMINISTRATION RECORD**HIGH DOSE****PLEASE ANSWER ALL QUESTIONS****65+**

1. Have you had any other injections in the last month? ☐ YES ☐ NO
2. Are you allergic to eggs or chicken? ☐ YES ☐ NO
3. Do you have a fever or feel ill today? ☐ YES ☐ NO
4. Have you ever had a reaction to the flu shot before? ☐ YES ☐ NO

The doctor or clinic may keep this record in your medical file or your child's medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

I have read or have had explained to me the information about influenza and 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 the person named below from whom I am authorized to make this request.

Information about person to receive vaccine. (Please print)					
Name: Last	First	M.I	Sex	Birthdate	Age
Address: Street	City	County	State	Zip	
Telephone Number:					
Medical Assistance Number or <u>BOTH</u> Medicare and Supplemental Health Insurance Name & Number					
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 to process this claim. If Medicare does not cover this claim, I agree to pay for vaccines administered to me.					
X _____ Date _____					

PLEASE NOTE: MAKE SURE YOU PRESENT YOUR MEDICARE HMO CARD FOR BILLING PURPOSES. IF YOUR CLAIM IS DENIED, YOU WILL BE BILLED FOR SERVICES.

*******FOR CLINIC/OFFICE USE*******

Clinic/Office Address: MARQUETTE COUNTY HEALTH DEPARTMENT

Date Vaccine Administered: _____

Vaccine Manufacturer SEQIRUS/FLUAD HIGH DOSE TRIVALENT

Vaccine Lot Number 418598 EXP. DATE 5-15-2027

Site of Injection: LEFT DELTOID RIGHT DELTOID

Signature of Vaccine Administrator: _____

Title of Vaccine Administrator: RN