



Sussex County Health Unit
544 S. Bedford St.
Georgetown, DE 19947

Seaford Public Health
350 Virginia Ave
Seaford, DE 19973

Milford Health Unit
253 NE Front St
Milford, DE 19963

Kent County Health Unit
805 River Rd.
Dover, DE 19901

Hudson S.S.C.
501 Ogletown Rd.
Newark, DE 19711

Influenza Vaccination Administration Record

Patient's last name:		First:	Middle:	Gender:		
				M <input type="checkbox"/> F <input type="checkbox"/> Trans <input type="checkbox"/> Other <input type="checkbox"/>		
Street address:				Phone:		
City:			State:	ZIP Code:		
Date of Birth:		Age:		Hispanic Ethnicity:		
mm/dd/yyyy				Yes <input type="checkbox"/> No <input type="checkbox"/>		
Haitian? Yes <input type="checkbox"/> No <input type="checkbox"/>						
Race (Check all that apply): White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/>						
Insurance: None <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP/DHCP* <input type="checkbox"/> Private <input type="checkbox"/> _____						
Medicaid/Medicare #			MCO (if insured by Medicaid):			
			Highmark <input type="checkbox"/> AmeriHealth <input type="checkbox"/> Other <input type="checkbox"/> _____			
Medical Screening				Yes	No	Clinician's Note
Is the person to be vaccinated sick today?				<input type="checkbox"/>	<input type="checkbox"/>	
Has the person to be vaccinated ever had a serious allergic reaction to:				<input type="checkbox"/>	<input type="checkbox"/>	
<ul style="list-style-type: none"> Influenza vaccine? Eggs, egg proteins? Natural rubber latex; or other substances? _____ 						
Has the person to be vaccinated ever had Guillain-Barré syndrome?				<input type="checkbox"/>	<input type="checkbox"/>	
What is the weight of the person being vaccinated (best guess)?				___ lbs		

My signature (below) means that I have been given a copy of the appropriate Vaccine Information Statement (VIS) and have read, or have had explained to me, information about the disease and the vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits as set forth in the VIS I was given and I ask that the vaccine be given. Also, by signing below I hereby give my consent for DPH to bill my insurance based on eligibility for the vaccine received.

Signature _____ **Date** _____

Signer's Name _____ **Patient** **Parent** **Guardian**

Print Clearly

Do not write below this line. For Clinician use only.

NHS ___ **SHS** ___ **Clinic Location:** _____

Preparation/Route	Dose	Site	Vaccination Date
Flucelvax®/MDCK Quad P-Free Inj./IM _____	0.5ml _____	RA ___ RT ___ LA ___ LT ___	
Fluarix®/Quad Inj. P-Free/IM _____			
VIS Date 8/07/2015	Date VIS Given _____	Manufacturer: Seqirus, GSK <small>circle one</small>	Lot # _____

Clinician's Signature: _____ **License Title** _____

- VFC** – Child is under age 19 and [Use FED]
 - Child is enrolled in Medicaid or
 - Child is uninsured or
 - Child is American Indian or Native Alaskan
- Child is enrolled in **Delaware Healthy Children's Program (DHCP*)** [Use FED]
- None of the above (child or adult) [Use STATE]