# CARROLL COUNTY GENERAL HEALTH DISTRICT

## Influenza Vaccine Administration Record

| Name: | Birthdate: | Age: | Sex: |
|---|---|---|---|
| Address: | | | |
| Phone: | | | |
| Social Security Number: | | | |

**Please answer the following questions:**

**1. Are you sick today?** **____ Yes** **____ No**
**2. Are you allergic to eggs or an influenza vaccine component?** **____ Yes** **____ No**
**3. Do you have a latex allergy?** **____ Yes** **____ No**
**4. Have you had an allergic reaction to medications, food, or any vaccines?** **____ Yes** **_____No**

**Please place a check beside each of the following statements:**

**____ I have received a copy of the influenza vaccine information sheet.**

**____ To the best of my knowledge, I understand the benefits and/or risks of the influenza vaccine.**

**____ I have had a chance to ask questions about the vaccine that were answered to my satisfaction.**

**____ I request to receive the influenza vaccine, or request the vaccine be given to the above-named individual for whom I am authorized by law to make said request.**

**____ I have received and/or have explained to me the Carroll County General Health District (CCGHD) Notice of Privacy Practices Summary which explains the policies concerning my personal health information.**

**My signature below authorized the CCGHD to release to the below named insurance company and medical or other information required to process a claim for benefits. I understand that the CCGHD will accept assignment of any claim and my signature below authorizes said intermediary to pay benefits on my behalf, directly to the CCGHD. I understand that any information so released will be treated as confidential by the CCGHD, in accordance with the HIPPA policies.**

**Parent/Guardian Signature _____ Date: _____**

| | | |
|---|---|---|
| **Lot Number:** | **Anthem**<br>**Aultcare**<br>**Cigna**<br>**Summa**<br>**Medical Mutual**<br>**United Health Care**<br>**Ohio Health Choice** | **Buckeye**<br>**Caresource**<br>**Molina**<br>**Paramount**<br>**UHC Community Plan** |
| **LA LL RA RL** | | |
| **Nurse Initials** | | |