*LHD name*_____
*LHD address*_____
*Off-site Location*_____

PEF label OR

DOCUMENT#: _____

HID/LOC/SITE: _____

SEASONAL Influenza and/or H1N1 Influenza VACCINE ADMINISTRATION RECORD

NAME: _____ **SOCIAL SECURITY#:** _____

ADDRESS: _____
STREET CITY COUNTY STATE ZIP

BIRTHDATE: ____/____/____ **PHONE NUMBER:** _____
MONTH DAY YEAR

RACE: (Check ONE or MORE) ☐ **(W)** White ☐ **(B)** Black or African American ☐ **(N)** American Indian or Alaska Native

☐ **(A)** Asian ☐ **(H)** Native Hawaiian or Other Pacific Islander **ETHNICITY:** Hispanic or Latino **(Y)** Yes or **(N)** No

SEX: (Check ONE) ☐ Male ☐ Female **Vaccine For Children (**seasonal flu**) ELIGIBLE?** ☐ YES ☐ NO

DO YOU HAVE **MEDICAID** ? ☐ YES ☐ NO IF YES, **MEDICAID NUMBER**: _____

DO YOU HAVE **MEDICARE** ? ☐ YES ☐ NO IF YES, **MEDICARE NUMBER**: _____

DO YOU HAVE **HEALTH INSURANCE** ? ☐ YES ☐ NO

IF YES, **COMPANY NAME:** _____ **POLICY#:** _____

SUBSCRIBER'S NAME: **GROUP #:**

The health department may keep this record in a 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 vaccine injection site, 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 2009-2010 Vaccine Information Statement(s) (VIS) and understand the risks and benefits for the: (Check box(es))

- **( ) 2009-2010** *Inactivated* ***influenza vaccine, (VIS/EPID-239A Dated 08/11/09)***
- **( ) 2009-2010** *Live,* ***Intranasal influenza vaccine, (VIS/EPID-239B Dated 08/11/09)***
- **( ) 2009-2010** *Inactivated* ***H1N1 influenza vaccine, (VIS dated 10/2/09)***
- **( ) 2009-2010** *Live,* ***Intranasal H1N1 influenza vaccine, (VIS dated 10/2/09)***

☐ **ASSIGNMENT OF BENEFITS** I request that payment of authorized medical insurance benefits be made to the local health department listed above on behalf of above name, for services received. I also authorize the local health department to release medical information to Medicare, Other Third Payors (insurance carriers, Medicaid, etc.) and their agents to determine payment for services. I am aware that should Medicare refuse payment for the seasonal influenza vaccine service, I will be responsible for the cost. If I am covered by a billable private insurance, I am aware that I may be responsible for some additional charges not covered by my plan for the seasonal influenza vaccine. **I will not be responsible for any charges for the H1N1 vaccine or administration.**

X_____ **DATE:** _____

Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian)

FOR HEALTH DEPARTMENT USE ONLY

(Seasonal Influenza Vaccine)

Vaccine Manufacturer:_____
Vaccine Lot Number:_____
Injection Site:_____
Signature and Title of Provider:_____
Provider:_____

(H1N1 Influenza Vaccine)

Vaccine Manufacturer:_____
Vaccine Lot Number:_____
Injection Site:_____
Signature and Title of Provider: _____
Provider# :_____

√	INFLUENZA (VFC)	√	INFLUENZA (NON-VFC)
	90655 Influenza:split-presrv free- ages 6-35 mths		90655NV Influenza:split-presrv free- ages 6-35 mths
	90656 Influenza:split-presrv free- ages 3-18 yrs		90656NV Influenza:split-presrv free- ages 3-18yrs
			90656 Influenza:split-presrv free- ages >18yrs
	90657 Influenza:split- ages 6-35 mths		90657NV Influenza:split- ages 6-35 mths
	90658 Influenza:split- ages 3-18 yrs		90658NV Influenza- ages 3-18 yrs
			90658 Influenza- ages >18 yrs
	90660 Influenza:Intranasal-ages 2-18 yrs		90660NV Influenza: Intranasal- ages 2-18 yrs
	(Use FR Modifier if NO Insurance or Under-insured)		90660 Influenza: Intranasal- ages 19-49 yrs

√	ADMINISTRATION of H1N1 or Seasonal INFLUENZA Vaccine
	G0008 Administration of Influenza Vaccine **ICD Code:** V0481 Need for prophylactic vaccination
	(Circle one) G9141 **or** 90470 Administration of H1N1 Influenza Vaccine _____ Dose 1 _____ Dose 2

(Seasonal Flu) Self Pay ONLY: Amount Collected $_____ Signature:_____
(If different that authorized person above)