Influenza Vaccine ☐ LEP
ADMINISTRATION RECORD
(NO third party billing)

Lexington-Fayette County Health Department
650 Newtown Pike, Lexington, KY 40508
(859) 288-2483 option 2
www.lexingtonhealthdepartment.org

NAME: _____

ADDRESS: _____
STREET CITY COUNTY STATE ZIP

BIRTHDATE: _____/_____/_____ **AGE:** _____ **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 ☐ **(N)** No

SEX: (Check ONE) ☐ Male ☐ Female

ANNUAL HOUSEHOLD INCOME: (Check ONE)
☐ Less than or equal to $25,000 ☐ $25,001-$50,000 ☐ $50,001-$74,999 ☐ Greater than or equal to $75,000 ☐ Do not know
☐ Do not wish to respond

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. All patient information will remain confidential. Demographic information, such as income and insurance status, may be used internally to assist in planning similar events in the future. If you do not wish to answer questions regarding income or insurance status, please select "Do not wish to respond." **I am not responsible for any charges for the influenza vaccine or administration.**

I have read or have had explained to me the 2017-2018 Vaccine Information Statement (VIS) and understand the risks and benefits for the:
☐ **2017-2018** *Inactivated* ***influenza vaccine, (*VIS dated 08/07/15) (Injection)**

X _____ **DATE:** 10/5/17
Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian)

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Y	**N**	
☐	☐	Are you feeling well today?
☐	☐	Have you had a **2017-2018** flu vaccine? ____ Shot DATE:_____
☐	☐	**In your lifetime, have you ever received an influenza vaccine?**
☐	☐	Do you have a serious allergy to eggs? (This does **not** mean that you do not like them or they give you an upset stomach)
☐	☐	Do you have any other serious allergies? Please list_____
☐	☐	Have you ever had a serious reaction to a previous dose of flu vaccine?
☐	☐	Have you ever had Guillain-Barre Syndrome (a temporary severe muscle weakness) within 6 weeks of receiving a flu shot?

FOR HEALTH DEPARTMENT USE ONLY

VACCINE MANUFACTURER: _____ **VACCINE LOT NUMBER:** _____ ☐ Questions reviewed with patient

INJECTION SITE: Deltoid: ☐ Left ☐ Right Lateral Thigh: ☐ Left ☐ Right

SIGNATURE AND TITLE OF PROVIDER: _____ **PROVIDER#:** _____ **DATE:** 10/5/17

NOTES: _____

_____

☐ Dose 1 ☐ Dose 2