

**HEPATITIS A VACCINE  
ADMINISTRATION RECORD**

I have read or have had explained to me the information in the Vaccine Information Statement about Hepatitis A vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of Hepatitis A vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request.

<b>INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)</b>			
Name LAST:	FIRST:	MIDDLE INITIAL:	
Address:	Phone:	Birthdate:	M/F      WT. Age:
City:	State:	ZIP:	County:
Allergies:			
Physician Name:		Address:	

**FOR MEDICARE RECIPIENTS:** I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

**SEE ATTACHED COPY OF MEDICARE CARD IF MEDICARE ELIGIBLE**

SIGNATURE AUTHORIZING VACCINATION; of person to receive vaccine or person authorized to make request (parent or legal guardian) for vaccination		DATE:
X		
Patient signature above and Vaccinator signature below also indicates patient receipt of the current Hepatitis A Vaccine Information Statement on date signed.	VIS DATE:	CHRONIC ILLNESS [ ] YES    [ ] NO
DO NOT WRITE BELOW THIS LINE (CLINIC/OFFICE USE ONLY)		
***** FOR CLINIC/OFFICE USE ONLY		

PHARMACY/CLINIC NAME:	
ADDRESS:	
MEDICARE PIN:	
DATE VACCINE ADMINISTERED:	
VACCINE NAME & MANUFACTURER:	Havrix/GlaxoSmithKline      VAQTA/Merck
VACCINE LOT NUMBER & EXPIRATION DATE:	
SITE OF INJECTION /NEEDLE GAUGE / LENGTH	L Arm   R Arm / 25G 1½in   25G 1 in   Other
STRENGTH/DOSE GIVEN/ROUTE      Other Notes	0.5 mL   1.0 mL   IM      Notes:
SIGNATURE / TITLE OF VACCINE ADMINISTRATOR:	
Other Medications Administered (e.g., epinephrine, etc.)	

PAYMENT SOURCE: [ ] CASH   [ ] CHECK   [ ] * BILL MEDICARE   OTHER _____
* IF MEDICARE ELIGIBLE THE MEDICARE CARD IS REQUIRED.