INFLUENZA VACCINE
ADMINISTRATION RECORD

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

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)			
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 X		DATE:
Patient Signature above and Vaccinator signature below also indicates patient receipt of the current Influenza Vaccine Information Statement on date signed.	VIS DATE:	CHRONIC ILLNESS [ ] YES [ ] NO

DO NOT WRITE BELOW THIS LINE (CLINIC/OFFICE USE ONLY)

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FOR CLINIC/OFFICE USE ONLY

PHARMACY/CLINIC NAME:	
ADDRESS:	
MEDICARE PIN:	
DATE VACCINE ADMINISTERED:	
VACCINE NAME & MANUFACTURER:	Afluria Quadrivalent (Seqirus) Fluad Quadrivalent (Seqirus) Fluarix Quadrivalent (GSK) Flucelvax Quadrivalent (Seqirus) FluLaval Quadrivalent (GSK) FluMist Quadrivalent (AstraZeneca) Fluzone Quadrivalent (sanofi pasteur) Fluzone High-Dose Quadrivalent (sanofi pasteur)
VACCINE LOT NUMBER & EXPIRATION DATE:	
SITE OF INJECTION / NEEDLE GAUGE / LENGTH	L Arm R Arm / 25G 1in 25G 5/8in Other:
STRENGTH/DOSE GIVEN & ROUTE Other Notes	0.5mL/IM 0.7mL/IM 0.2mL/intranasal Notes:
Other Medications Administered (e.g., epinephrine, etc.)	
SIGNATURE / TITLE OF VACCINE ADMINISTRATOR: (Administering pharmacist OR pharmacy intern & supervising pharmacist)	
PAYMENT SOURCE: [ ] CASH [ ] CHECK [ ] * BILL MEDICARE OTHER _____ * IF MEDICARE ELIGIBLE THE MEDICARE CARD IS REQUIRED.	