**MENINGOCOCCAL VACCINE**

# ADMINISTRATION RECORD

I have read or have had explained to me the information in the Vaccine Information Statement about meningococcal vaccines. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of meningococcal 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.<br>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<br><br>X | | DATE: |
|---|---|---|
| Patient signature above and Vaccinator signature below also indicates patient receipt of the current Meningococcal (MenACWY or MenB) Vaccine Information Statement on date signed. | VIS DATE: | CHRONIC ILLNESS<br>[ ] 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: | Menactra (sanofi pasteur ) Menveo (GlaxoSmithKline) MenQuadfi (sanofi pasteur )<br>Bexsero (Group B) (GlaxoSmithKline) Trumenba (Group B) (Pfizer) |
| VACCINE LOT NUMBER & EXPIRATION DATE: | |
| SITE OF INJECTION /NEEDLE GAUGE / LENGTH | L Arm R Arm / 25G 1½in 25G 1in 25G 5/8in Other |
| STRENGTH/DOSE GIVEN & ROUTE Other Notes | 0.5 mL IM SC 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.