

**Alabama Department of Public Health  
Vaccine Administration Form \***

Last Name (Print)	First Name (Print)	MI	Gender	Race	Date of Birth	Age
Insurance Policy Number, Medicaid Number, or Medicare Number				Group Number		
Street Address			Phone			
City		County	State		Zip Code	

I give permission for myself or the above named child to receive the vaccine indicated below. I authorize payment for the vaccine provided.

**NOTE:** For vaccine clinics in schools, the vaccine itself is provided free. An administration fee may be billed to the insurance (for example, private insurance, Medicaid, or Medicare) using my protected health information. Individuals will not be charged the administration fee in school-based clinics.

I have received notice of my privacy rights, and I have been given or offered a copy of the Alabama Department of Public Health "Notice of Privacy Practices." I have read and understand the Vaccine Information Statement and have had the opportunity to discuss it with the provider.

Influenza  MMR  Pneumococcal  Td  Tdap  Varicella  Other: \_\_\_\_\_  Pregnant-Additional vaccine information received

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date Vaccine and VIS Given	Type and Date of VIS	Clinic Site		
Vaccine Given	Manufacturer and Lot Number	Site of Injection LA RA LT RT	Route ID IM SQ NASAL	
Signature of Nurse				
Income Assessment: Medicaid Y ___ N ___ American Indian/Alaskan Native Y ___ N ___ Insurance Y ___ N ___ Family Size ___ Annual Income \$ _____ Payment Bracket _____ Fee Paid _____ Fee Waived _____ Initials of Assessor _____				

\*This form should be used for recording the administration of a vaccine when a Comprehensive Health Record (CHR) is not opened.