

Alabama Department of Public Health Influenza Vaccine Administration Form

			РА	TIEN	NT INFO	ORMAT	TION											
Last Name						irst Name							M.	I. Gender		der		
Race	American Indian or		Da			Date	te of Birth				_	Age	L					
Street Address					Phone													
Sileet Address									I none									
City				County State							Zip Code							
For school vaccine clinic, list sch	ool and check one	vaccine	e preference (eligi	ibility	for FLU	MIST is			• •					_				
School:						_		FL	LUMIST	Γ (adn	ninistered	l nasally	')	Injec	t able	Vaccine		
	C/LEGAL GUARDIAN INFORMATION FOR DEPENDENTS																	
Last Name	First Name Relationship to Patient																	
Street Address (if different)	(City				State			Zip	Zip					
Phone			Emergency Contact						1	Email								
			INSU	URAN	NCE INF	FORMA	ATION											
Insurance Provider (check one):	BCBS	AL	L Kids 🔲 Me	edicai	d 🔲 1	Medica	re 🔲 I	Blue	e Advan	itage	🔲 Unin	sured	[(Other				
Group Number			Insurance Polic	ey Nu	mber or l	Medicai	d Numb	er										
Cardholder Name	Cardholder Name Cardholder Date of Birth Relationship to Patient																	
				Self Parent Legal Guardian					ո 🗖 Տլ	Spouse 🔽 Other								
		VAC	CCINATION AN	ND H	EALTH	-RELA'	TED IN	FO	RMAT	ION								
Has the patient ever received a flu															YES	O no		
IF YES, was the flu dose received in the year 2010 or after?										YES	O NO							
Is the patient pregnant or will the patient become pregnant within the next month?											YES	O NO						
Is the patient younger than 5 years with asthma or one or more episodes of wheezing within the past year?										YES	O NO							
Does the patient have long-term health problems with: (Children with any of the conditions below will not meet requirements to receive FluMist.)										0	YES	O NO						
Heart DiseaseKidney or Liver Disea	se •		ung Disease Ietabolic Disease.	such	as Diaba	atas		•		hma mia an	d other B	lood Die	order	·e				
Does the patient have certain mus) that can	n lea							YES	O NO		
Does the patient have a weakened immune system?											YES	O NO						
Is the patient in close contact with someone whose immune system is weak and who requires care in a protected environment (such as a bone marror									YES	O NO								
transplant unit)? Does the patient have any life-threatening allergies, including a severe allergy to food (including eggs), a vaccine component, or latex?										0	YES	O no						
IF YES, please list:		-19														~		
Has the patient received vaccinati IF YES, please list:	lons in the past 4 we	eks?												0	YES	O NO		
Has the patient ever had a severe reaction after a dose of influenza vaccine?											_ o	YES	O no					
Has the patient had Guillain-Barré Syndrome (a severe paralytic illness, also called GBS)?												YES	O no					
FOR SCHOOL CLINICS (chec	ck one):			Pleas	se do not	adminis	ster any o	othe	er vaccir	ne, I on	ly want th	e FluMi	ist.					
If my child does not qualify for	FluMist:									(injecta	ible), I do	not nee	d to b	e contacto	ed.			
Y1 1.1 Y7 Y Y C		1 .			se contact					1 • 1	6.1	9		.				
I have read the Vaccine Informati above named patient to receive th																		
given or offered a copy of the Ala	ibama Department o																	
for review at the time of vaccinati	ion.																	
Signature (Parent o	r Guardian if under	14, or					<u> </u>	ess o	of age)					Date	3			
	· · · · · · · · · · · · · · · · · · ·		Ē		LINIC U	USE ON	NLY)	_										
Date Vaccine and VIS Given Type and Date of VIS Clinic					e County Code							NCES #						
Vaccine Given: FLUMIST FLUARIX FLUZONE FLUZONE HD						OTHER: VFC						Г	YES NO					
Site Type WELLNESS COUNTY CLINIC Manufacturer and					mber								n jection A LT R ⁻					
Nurse Signature					ГР	Pregnant-Additional vaccine information received									Second Dose Needed			
						5.0.1												

IMM-66 INFLUENZA