Alabama Department of Public Health
Influenza Vaccine Administration Form

PATIENT INFORMATION

Last Name	First Name	M.I.	Gender

Race	American Indian or Alaskan Native?	Date of Birth	Age
	☐ YES ☐ NO		

Street Address	Phone

City	County	State	Zip Code

For school vaccine clinic, list school and check **one** vaccine preference (*eligibility for FLUMIST is determined by questionnaire below*):

School: _____ ☐ FLUMIST (administered nasally) ☐ Injectable Vaccine

PARENT / LEGAL GUARDIAN INFORMATION FOR DEPENDENTS

Last Name	First Name	Relationship to Patient

Street Address (if different)	City	State	Zip

Phone	Emergency Contact	Email

INSURANCE INFORMATION

Insurance Provider (check one): ☐ BCBS ☐ ALL Kids ☐ Medicaid ☐ Medicare ☐ Blue Advantage ☐ Uninsured ☐ Other _____

Group Number	Insurance Policy Number or Medicaid Number

Cardholder Name	Cardholder Date of Birth	Relationship to Patient
		☐ Self ☐ Parent ☐ Legal Guardian ☐ Spouse ☐ Other_____

VACCINATION AND HEALTH-RELATED INFORMATION

Has the patient ever received a flu vaccination?	YES NO
IF YES, was the flu dose received in the year 2010 or after?	YES NO
Is the patient pregnant or will the patient become pregnant within the next month?	YES NO
Is the patient younger than 5 years with asthma or one or more episodes of wheezing within the past year?	YES NO
Does the patient have long-term health problems with: (*Children with any of the conditions below will not meet requirements to receive FluMist.)*	YES NO
• Heart Disease • Lung Disease • Asthma • Kidney or Liver Disease • Metabolic Disease, such as Diabetes • Anemia and other Blood Disorders	
Does the patient have certain muscle or nerve disorders (such as seizure disorders or cerebral palsy) that can lead to breathing or swallowing problems?	YES NO
Does the patient have a weakened immune system?	YES 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 marrow transplant unit)?	YES NO
Does the patient have any life-threatening allergies, including a severe allergy to food (including eggs), a vaccine component, or latex?	YES NO
IF YES, please list: _____	
Has the patient received vaccinations in the past 4 weeks?	YES NO
IF YES, please list: _____	
Has the patient ever had a severe reaction after a dose of influenza vaccine?	YES NO
Has the patient had Guillain-Barré Syndrome (a severe paralytic illness, also called GBS)?	YES NO

FOR SCHOOL CLINICS *(check one):*
If my child does not qualify for FluMist:

☐ Please do not administer any other vaccine, I **only** want the FluMist.
☐ Please administer the alternative vaccine (injectable), I do not need to be contacted.
☐ Please contact me and discuss further.

I have read the Vaccine Information Statement (VIS) about the influenza virus and vaccine. I understand the benefits and risks of the influenza vaccine. I give permission for the above named patient to receive the vaccine indicated. I authorize billing insurance for the vaccine provided. I have also 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 understand this information is available upon request, as well as available for review at the time of vaccination.

_____ _____
Signature (Parent or Guardian if under 14, or if receiving vaccination at school clinic regardless of age) Date

(FOR CLINIC USE ONLY)

Date Vaccine and VIS Given	Type and Date of VIS	Clinic Site	County Code	NCES #

Vaccine Given: ☐ FLUMIST ☐ FLUARIX ☐ FLUZONE ☐ FLUZONE HD ☐ OTHER: _____ **VFC** ☐ YES ☐ NO

Site Type	Manufacturer and Lot Number	NDC#	Site of Injection	Route
☐ WELLNESS ☐ COUNTY CLINIC			LA RA LT RT	IM NASAL

Nurse Signature ☐ Pregnant-Additional vaccine information received ☐ Second Dose Needed

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