



Screener initials

VACCINE ADMINISTRATION RECORD 2008-2009 FLU PROGRAM

PLEASE PRINT:

NAME: _____ Phone # (____) _____

Male Female
 Last _____ First _____ M.I. _____
 Date of Birth _____ Age _____

Address: _____
 Street/P.O. Box Apt # City State Zip Code

Contraindications for Pneumococcal Vaccine:	Contraindications for Flu:
<input type="checkbox"/> Previously immunized after the age of 65 <input type="checkbox"/> Previously immunized before age 65, but less than 5 years ago <input type="checkbox"/> Reported allergy to the vaccine <input type="checkbox"/> Running a fever	<input type="checkbox"/> Previously immunized this flu season <input type="checkbox"/> Ever had a serious allergic reaction to eggs <input type="checkbox"/> Previous serious reaction to influenza vaccine <input type="checkbox"/> History of Guillian-Barre syndrome <input type="checkbox"/> Running a fever <input type="checkbox"/> On aspirin therapy <input type="checkbox"/> Autoimmune Disease

Your signature indicates that you are providing information regarding ALL insurance coverage that you have; that the above information is accurate and complete; authorizes Southern Nevada Health District to bill contract insurance organizations or file a claim with Medicare Part B or other insurance providers as appropriate; authorizes the release of any medical or other information necessary to process this claim; authorizes payment of medical benefits to the Southern Nevada Health District for services described. It also indicates that you have received current written information regarding the vaccine(s) to be given.

SIGNATURE: _____ DATE: _____

ALL AREAS BELOW FOR SNHD STAFF ONLY

VACCINE	DATE GIVEN	MFG / LOT #	VIS DATE	SITE	ROUTE	GIVEN BY:	TITLE
FLU			7-24-08	LA	IM		LPN
				RA			RN
FLU MIST			7-24-08	IN			LPN RN
PNEUMONIA			7-29-97	LA	IM		LPN
				RA			RN
TD TDAP			6-10-94	LA	IM		LPN
			7-12-06	RA			RN

INSURANCE: (check one)

- Medicare B
 Railroad
 Other _____

INSURANCE NUMBER

Location

- MAIN HEND SPV
 ELV NLV

MEDICAID PLAN: (check one) MEDICAID NUMBER

- Medicaid _____
 NV Health Solutions (NCSH) _____
 Health Plan of Nevada (HPNH) _____

Amount Paid

\$ _____

- Gratis

Record # _____

Clerical initials