

**SEASONAL FLU VACCINE ADMINISTRATION RECORD
CHILD (6 MONTHS THRU 18 YEARS) 2020-2021**

For Office Use Only
<input type="checkbox"/> Billing Done
<input type="checkbox"/> Cpis Entered
<input type="checkbox"/> Bill Other _____
<input type="checkbox"/> Trade Done

Child's Name: LAST, FIRST, Middle initial Birth date Age (yrs. or mos.)
Address _____ **Phone** _____
Parent Name: _____ **Has child had shots at PH before? Yes__ No__**
Type of Payment: Cash Check Credit Card Bill Insurance
Insurance Policy Holder Name _____
Insurance Policy Holder Date of Birth _____
Child's Medicaid State ID# _____ **No Insurance** _____

“I have read or have had explained to me the information in the SEASONAL flu vaccine information sheet given to me about SEASONAL influenza and its vaccine. I have had an opportunity to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of SEASONAL influenza vaccine and ask that the SEASONAL flu vaccine be given to me or to the person named above for whom I am authorized to make this request.”

PARENT SIGNATURE: _____

SCREENING QUESTIONS	NO	YES
1) Do you have a life-threatening allergy to eggs?		
2) Have you ever had a severe reaction to a previous flu shot?		
3) Have you ever been diagnosed with Guillian-Barre' Syndrome? (A paralyzing illness?)		
4) Are you moderately or severely ill today? (If you are on antibiotics but feeling well, check NO)		
5) Are you pregnant?		

For Office Use:

Location: Gunnison Fairgrounds or Crested Butte Community School

Dose: Fluarix 0.5 mL IM VIS 8/15/19

Vaccine Lot: #1 #2

Site: LT RT LD RD

Signature of SEASONAL flu Vaccine Administrator: _____

Date flu vaccine given: 10/6/20 10/7/20 Other: _____