



# INFLUENZA VACCINE RECORD

## Information About Person to Receive Vaccine (Please Print)

_____		_____		_____	
Last Name		First Name		Middle Name	
_____				_____	
Mailing Address				Apt/Suite	
_____		_____	_____	_____	
City		State	Zip	County	
_____		_____			
Date of Birth		Phone Number			
<b>GENDER</b>		<b>RACE (Check all that apply)</b>		<b>HISPANIC ORIGIN</b>	
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Aleut <input type="checkbox"/> Japanese <input type="checkbox"/> Arabian <input type="checkbox"/> Korean <input type="checkbox"/> Asian Indian <input type="checkbox"/> Laotian <input type="checkbox"/> <b>Black</b> <input type="checkbox"/> Other Asian <input type="checkbox"/> Cambodian <input type="checkbox"/> Refused <input type="checkbox"/> Chinese <input type="checkbox"/> Samoan <input type="checkbox"/> Eskimo <input type="checkbox"/> Thailander <input type="checkbox"/> Filipino <input type="checkbox"/> Unknown <input type="checkbox"/> Guamanian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hawaiian <input type="checkbox"/> <b>White</b> <input type="checkbox"/> Indian <input type="checkbox"/> <b>Other (Specify):</b> _____		<input type="checkbox"/> Cuban <input type="checkbox"/> <b>Non-Hispanic</b> <input type="checkbox"/> Mexican <input type="checkbox"/> Unknown <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Refused <input type="checkbox"/> South or Central American <input type="checkbox"/> Unknown Hispanic <input type="checkbox"/> <b>Other (Specify):</b> _____	
<b>SPOKEN LANGUAGE</b>				<b>HEALTH PLAN</b>	
<input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> <b>English</b> <input type="checkbox"/> Portuguese <input type="checkbox"/> French <input type="checkbox"/> Refused <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Haitian Creole <input type="checkbox"/> <b>Spanish</b> <input type="checkbox"/> Hmong <input type="checkbox"/> Unknown <input type="checkbox"/> Italian <input type="checkbox"/> Vietnamese <input type="checkbox"/> <b>Other (Specify):</b> _____				<input type="checkbox"/> CHIP <input type="checkbox"/> No Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Ins. <input type="checkbox"/> Unknown <input type="checkbox"/> Other <input type="checkbox"/> <b>Medicare:</b> Write Medicare # below _____	
<b>DO YOU HAVE DIABETES?</b>		<b>COAL MINER</b>			
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> Active Miner <input type="checkbox"/> Retired Miner <input type="checkbox"/> Miner's Spouse			
Did you ever have a reaction to a previous dose of flu vaccine?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a serious allergic reaction to eggs?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a history of Gullian-Barre Syndrome (a severe paralytic illness)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>I have read or have had explained to me the information in "Vaccine Information Statement: Inactivated Influenza Vaccine: WHAT YOU NEED TO KNOW( 7/2/12)." I have had a chance to ask questions. Any questions were addressed to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.</p>					
X _____			_____		
Signature			Date		
<b>For Clinic Use Only</b>					
Vaccination Date: _____		Dosage Volume: _____		_____ Signature of Vaccine Administrator _____ Signature Date	
Injection Site: _____		Route: _____			
Manufacturer: _____		Lot Number: _____			