Health Department

CHILD FLU VACCINE ADMINISTRATION RECORD

(6 Months through 18 Years of Age) Date: Time:

SECTION 1: CHILD INFORMATION *(Please PRINT clearly)*

Legal Last Name:		**Legal First Name:**		**Middle Name:**	
Other Names Used Since Birth:					
Street Address:		**City:**		**State:**	**Zip Code:**
Date of Birth: *mm/dd/yy*		**Phone #**	☐ Cell ☐ Home (Landline)	**Gender:**	☐ Male ☐ Female

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Native Alaskan/American Indian ☐ Multi-Racial (Select all that apply)

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

PARENT/RESPONSIBLE PARTY

Last Name:		**First Name:**		**Relationship:**	☐ Parent ☐ Legal Guardian ☐ Power of Attorney

SECTION 2: INSURANCE

Which of the following best describes your insurance coverage?

☐ Blue Cross Blue Shield
☐ Blue Care Network
☐ Health Alliance Plan (HAP)
☐ McLaren Health Advantage
☐ Priority Health
☐ Total Health Care
☐ Tricare
☐ Medicaid
☐ Medicaid Health Plan
☐ I do not have Insurance
☐ Insurance Not Listed
*If insurance not listed, does it cover the cost of vaccines?
☐ Yes
☐ No

Enter Insurance Information: *Only complete if your insurance is listed above*

Primary Subscriber Name:	☐ Self ☐ Parent	**Primary Subscriber Birthdate:** *mm/dd/yy*	
Policy/Contract Number:		**Group Number:**	

SECTION 3: MEDICAL SCREENING QUESTIONNAIRE

1. Ever had a serious reaction to a vaccine?	☐ Yes ☐ No
2. Allergic to eggs, Thimerosal, gelatin, latex or any antibiotics?	☐ Yes ☐ No
3. Received an influenza vaccination during any past flu seasons?	☐ Yes ☐ No
4. Ever had Guillain-Barré Syndrome (GBS)?	☐ Yes ☐ No
5. Have any long-term health problem such as heart or lung disease, kidney disease or metabolic disease?	☐ Yes ☐ No
6. Have a cochlear implant, CSF leak, or a non-functioning spleen?	☐ Yes ☐ No
7. Have severe thrombocytopenia (low platelet count) or a bleeding disorder?	☐ Yes ☐ No
8. Currently ill or running a fever?	☐ Yes ☐ No
9. Have asthma, had an episode of wheezing in the past 12 months?	☐ Yes ☐ No
10. Currently receiving aspirin therapy?	☐ Yes ☐ No
11. Are or may be pregnant?	☐ Yes ☐ No
12. Received any vaccine within the past 30 days?	☐ Yes ☐ No
13. Received a flu antiviral medication in the past month?	☐ Yes ☐ No
14. Have cancer, leukemia, lymphoma, or any immune deficiency disease (inability to fight infection) or currently receiving chemotherapy, radiation therapy or steroid therapy (prednisone or cortisone)?	☐ Yes ☐ No
15. Have close contact with anyone who has a severely weakened immune system (for example, an individual who has had a bone marrow transplant and is currently in a hospital isolation room)?	☐ Yes ☐ No

SECTION 4: STATEMENT NOTICES & CONSENTS

A **IN REGARDS TO COMMERCIAL INSURANCES ACCEPTED BY MACOMB COUNTY HEALTH DEPARTMENT:** I authorize any holder of medical information about my child/me to release to commercial insurance or their intermediaries or carriers, information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment below.

See Page 2 on Reverse Side

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B	**NOTICE OF PRIVACY PRACTICES:** I have received a copy of Macomb County Health Department's Notice of Health Information Practices. I understand that my acknowledgement of the Notice is evidenced by my signature on this document. The Department is required to abide by the terms of this privacy notice. The Department may change the terms of its notice at any time. The new notice will be effective for all protected health information that it maintains at that time. Upon my request, the Department will provide me with the revised notice of privacy practices.

C	**CONSENT FOR SERVICE:** I have read or have had explained to me, the information contained in the Vaccine Information Statement(s) regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Macomb County Health Department to release my immunization record information, or the immunization record information of the person for whom I am authorized to make this request to other health care provider(s) as needed and to other public health authorities (e.g., for entry into an immunization registry for influenza reporting requirements).

By signing below, I hereby acknowledge that I have read and fully understand the applicable statements (A, B, and C) on this form.

SIGNATURE of Parent/Legal Guardian		**Date**	
PRINT NAME of Parent/Legal Guardian			

----------Office Use Only----------

Last Name:		**First Name:**		**Client ID #**	
Date of Service					

Service Location	Verified Method of Payment			
	Insurance	**VFC**	**Self-Pay**	**Fee Waiver**
☐ 91 – MC Outreach ☐ 92 – SW Outreach ☐ 93 – SE Outreach ☐ 01 - MC ☐ 02 - SW ☐ 03 - SE	☐ Medicaid ☐ BCBS ☐ BCN ☐ HAP ☐ McLaren ☐ Priority Health ☐ Total Health Care ☐ Tricare	☐ No Insurance (VFC) ☐ Unlisted insurance that does not cover vaccines (VFC) *Insurance Name (if available):* _____	☐ Unlisted insurance that covers vaccines - (Self Pay) *Insurance Name (if available):* _____ ☐ Cash ☐ Check ☐ Credit Card	☐ Fee Waived No Pay - Code 250

Vaccine Documentation

Nurse Staff ID:		**Nurse Confirmation of Birthdate:** *MM/DD/YYYY*	

Vaccine	CP/State	Manufacturer/Lot#	Route	Site	VIS Date	VIS Given
FLVQ (IIV4) *6 Months and Older*	☐ CP ☐ State		IM	☐ RT ☐ RD ☐ LT ☐ LD	8/6/2021	☐
FLCX (ccIIV4) *2 Years and Older*	☐ CP		IM	☐ RT ☐ RD ☐ LT ☐ LD	8/6/2021	☐
FLBQ (RIV4) *18 Years and Older*	☐ CP		IM	☐ RT ☐ RD ☐ LT ☐ LD	8/6/2021	☐
FLMQ (LAIV4) *2 Years through 49 Years*	☐ CP ☐ State		IN (IntraNasal)	☐ IN	8/6/2021	☐

NEXT DATE DUE FOR IMMUNIZATIONS *(if applicable)*: _____

PROGRESS NOTES	