Alabama Department of Public Health
Influenza Vaccine Administration Form

PATIENT INFORMATION

Last Name	First Name	M.I.	Gender
Last 4 Digits of Social Security Number	Date of Birth	Age	
Street Address	Phone		
City	County	State	Zip
School:_____			

PARENT / LEGAL GUARDIAN INFORMATION FOR DEPENDENTS

Last Name	First Name	Relationship to Patient ☐ Parent ☐ Legal Guardian ☐ Other _____
Street Address if Different	City	State / Zip
Phone	Emergency Contact	

INSURANCE INFORMATION

Insurance Provider (check one): ☐ Humana ☐ SEIB ☐ PEEHIP ☐ LGB			
Group Number	Insurance Policy Number or Medicare Number		
Card Holder Name Last First	Card Holder 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
Does the patient have long-term health problems with: • Heart Disease • Lung Disease • Asthma • Kidney or Liver Disease • Metabolic Disease, such as Diabetes • Anemia and other Blood Disorders	☐ Yes	☐ No
Does the patient have any life-threatening allergies, including a severe allergy to food (including eggs), a vaccine component, or latex? IF YES, please list: _____	☐ Yes	☐ No
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

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. I understand this consent form is effective for six months from date of signature and any health changes to the child will be reported to the school nurse.

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**	**Clinical Site**	**County Code**	**NCES #**
Vaccine Given: ☐ FLUARIX ☐ OTHER:_____				
Site Type: **☐ WELLNESS ☐ COUNTY CLINIC**	**Manufa**	**# 0-0884-52**	**Site of Injection** **LA RA**	**Route** **IM**
Nurse Signature			**Date**	

Type and Date of VIS:
Inactivated Influenza 8/06/2021
Manufacturer/Lot#: GSK NG5FM
NDC#: 58160-0884-52 Exp: 06/30/2025