CRH INFLUENZA VACCINATION ADMINISTRATION RECORD

(PLEASE FILL IN ALL LINES COMPLETELY, PRINT YOUR NAME AS IT APPEARS ON YOUR INSURANCE CARD.)

Last Name _____ First Name _____ Middle Initial _____
Address _____ City _____ State _____ Zip _____
Phone _____ Birth Date_____ Social Security # (optional) _____

Circle one: Male Female

Circle one: Insured Not Insured

Primary Insurance _____
Subscribers Name: _____
Subscribers Date of Birth: _____

Insurance Number: _____
Group Number: _____

Secondary Insurance _____
Subscribers Name: _____
Subscribers Date of Birth: _____

Insurance Number: _____
Group Number: _____

Cost: Free for most insurances. If no insurance the cost is $35 for regular dose or $50 for high dose. Recommendation of which dose to receive will be discussed at time of service.

READ THE STATEMENTS BELOW, THEN SIGN AND DATE THE FORM

1. I am not sick today.
2. I am not allergic to eggs, chickens or chicken feathers or had an allergic reaction to the flu shot before.
3. I am not allergic to Thimerosal. (found in some eye drops and contact solution)
4. I do not have a history of Guillain-Barre Syndrome or a persistent neurological disorder.
5. I have read the Influenza Vaccine Information Sheet and have had any questions answered to my satisfaction.
6. I understand the benefits and risks of the flu shot, and ask that the flu shot be given to me (or to the person for whom I am authorized to make this request.)
7. I accept responsibility for seeking medical attention if a problem occurs after having been given this vaccine.

SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY

Name of Vaccine:
Fluzone Fluzone HD >65

Vaccine Manufacturer: Sanofi Pasteur

Date Administered _____

Lot # _____ Expiration Date _____

Site of Injection: right deltoid left deltoid

Signature _____