Last Name: ______________________ First Name: ______________________ M.I. ______

Address: ______________________ (Number/Street Address & Apartment Number) ______________ (City & State) ________ Zip Code

Phone Number: ______________________ (Area Code & Phone Number) County: ______________

Birth Date: ____________ (Month/Day/Year) Age: ______ Social Security Number: ______________ Sex: M F Race: __________

Please answer the following questions:	YES	NO
Are you allergic to latex, eggs, thimerosol, or any components of the flu vaccine? →		
Are you ill today with a fever? →		
Were you ever paralyzed with Guillain-Barre Syndrome? →		
Do you have an active neurological disorder? →		
Are you taking Coumadin or Theophylline medication? →		
Are you Pregnant? →		
Do you live with or are you a close contact with a child 6 months of age or younger? →		
Are you a health care worker or a caregiver? →		
Are you currently taking chemotherapy, steroid therapy, or a close contact with someone who is? →		
Do you have a chronic illness? (If ***yes*** circle all that apply) → 1. Heart Disease; 2. Diabetes; 3. Pulmonary Disease (include **Asthma**); 4.Kidney Disease; 5.Other:___________		

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Please Check if you have:

___ **Private Insurance**: ______________Insurance Carrier ______________ Policy ID____________ Group #____________

___ **Medicare** Beneficiary Claim Number (HIC) _______ _______ _______ - _______ Aetna Anthem Railroad

___ **Medicaid** Claim Number (ID) ______________________________ Caresource Molina Unison Wellcare

___ **Employer Paying? If yes, name of employer** ______________________________

___ **Other/VFC Eligible**

VACCINE ADMINISTRATION RECORD

The doctor or clinic may keep this record in your medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's lot number, and the address where the vaccine was given. "I have read or have had explained to me the Vaccine Information Statement about seasonal influenza, H1N1, or pneumonia vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza, H1N1, and/or pneumonia vaccine(s) and ask that the vaccine(s) be given to me or the person named below for whom I am authorized to make this request."

Signature of person to receive vaccine or person to make the request (parent or guardian): The presence of my signature acknowledges that I have had the opportunity to review or receive a copy of the Erie County Health Department's Notice of Privacy Practices, received a Vaccine Information Sheet, and I am consenting to have my information entered into the state database. I consent to receive the **Seasonal Influenza Vaccination, H1N1 Vaccination, and/or Pneumonia Vaccination.**

______________________ Please Print Name X______________________ Signature **Date:** __________

Staff Use Only:	**Seasonal Influenza**	**Flu Mist**	**H1N1 Influenza**	**Pneumonia**
VIS Date	*08/11/09*	*08/11/09*	*10/02/09*	*04/16/09*
Date VIS Given & Vaccine Administered				
Vaccine Manufacturer				
Vaccine Lot Number				
Vaccine Expiration Date				
Site of Administration	*LA RA*	*Nasal*	*LA RA Nasal*	*LA RA*
Signature of Vaccine Administrator				
Clinic No. ____________	*ODH PP*	*ODH PP*	*ODH PP*	*ODH PP*