Flu Vaccine Administration Record

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle or Maiden

Insurance Information

Status: ☐ New ☐ Established Insurance: ☐ Star ☐ Medicaid ☐ CHIP ☐ Other:_____

☐ Chart Number:_____

History

Contraindications to receiving the flu vaccine: (Please check all that apply)

Known allergies to eggs, chicken, or chicken feathers	☐ Yes ☐ No
History of Guillain-Barre syndrome	☐ Yes ☐ No
Sensitivity to mercury	☐ Yes ☐ No
Current fever	☐ Yes ☐ No
Previous problems with the flu vaccine	☐ Yes ☐ No

Patient or Parent Signature: _____ Date:_____

Billing Information

As a courtesy to you, River Hills Family Medicine (RHFM) will file this claim with your insurance carrier. In the event your insurance Does not cover the vaccine and medical visit, you will receive a bill from RHFM. By signing this waiver, you agree to pay for the Vaccine services in the event that it is not a covered benefit under your insurance plan.

Patient or Parent Signature: _____ Date:_____

Internal Use Only

If "Yes" to any of the above questions, consult with provider. If "No" to all of the above answers, this patient is authorized to receive the appropriate dose and number of recommended doses of the flu vaccine.

Dosing Recommendations

6 to 35-months	0.25 cc IM (1 to 2 doses)*	☐ Regular	☐ Preservative-free
3 to 8-years	0.50 cc IM (1 to 2 doses)*		
9-years or older	0.50 cc IM (1 dose)		

*Note: Patients under 9-years old who have never received an influenza vaccine should receive the 2-dose regimen with 1-month between doses. Both doses are recommended for maximum protection. A single dose is considered sufficient for those patients under 9-years old that have received at least one prior dose of influenza virus vaccine.

Vaccine Information

DX: ☐ Preventative ☐ High-risk_____ Vaccine supplied by: ☐ RHFM ☐ State of Texas

Manufacturer: ☐ Aventis ☐ Sanofi Lot No.:_____ Exp. Date:_____

Amount: ☐ 0.25 cc IM ☐ 0.50 cc IM Site: ☐ Right ☐ Left ☐ Deltoid ☐ Anterior thigh

Patient received Flu Vaccine Information Statement: ☐ Yes ☐ No Edition Date:_____

Nurse Signature: _____ Date: _____

Provider Signature:_____ Date Reviewed:_____

Please return completed form to the appropriate physician's office.

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