UMDHU Respiratory Influenza Adult Administration Form

Please Print

Patient's Name (Last, First, Middle Initial)	**Date of Birth**	**Gender (circle)** **Male Female**	
Address (Street or PO Box)	**City**	**State**	**Zip Code**
Home Telephone/Cell Number	**County**		

Choose Payment Box and Complete Information in that Box

Medicare B Number:

BCBS Supplemental Policy Number:

United Health Care:

Humana Policy Number:

Secure Horizons Direct Policy Number:

Other: Name, Mailing Address and Policy Number:

Medicaid Number:

Name and Mailing Address of Company - Pay:

Self Pay: ☐

Blue Cross/Blue Shield Insurance
Policyholder Information
Last Name:
First Name:
Middle Initial:
Date of Birth:
Gender: Male Female
Policy Holder Relationship to Client:
Policy Number:
Group Number if applicable:
Name of Company (ex: BCBS of ND, TX, MT):
Address:

I hereby authorize Upper Missouri District Health Unit to release any information concerning my visit here to process any third party claim. I give my permission for UMDHU to administer my flu vaccination. I have received the Vaccine Information Sheet and have been given the chance to ask questions and have any questions answered. I acknowledge receipt of Upper Missouri District Health Unit's "Notice of Privacy Practices".

_____ _____

Signature/Person to receive vaccine or person authorized to sign on client's behalf **Date**

Reviewed by: _____

OVER ⟶

Flu Screening Questions: **Screener's Comments**

1. **Do you have a serious allergy or reaction to eggs, food, medication or thimerosal (a mercury preservative in vaccine) Please list allergies or medications:** **Yes No** _____
2. **Do you take any aspirin or any blood thinning medications daily?** **Yes No** _____
3. **Have you received any vaccines in the last month?** **Yes No** _____
4. **Are you on any chemotherapy?** **Yes No** _____
5. **Do you have a medical condition like diabetes, heart, lung or kidney disease that requires seeing a doctor?** **Yes No** _____
6. **Are you pregnant or nursing?** **Yes No** _____
7. **Do you have asthma, recurrent wheezing or use a nebulizer?** **Yes No** _____
8. **Do you have a healthy immune system?** **Yes No** _____
9. **Have you been ill in the last two days or have a cold now?** **Yes No** _____
10. **Have you ever had a serious reaction to a flu shot? (i.e. hospitalized/needed medical treatment)** **Yes No** _____
11. **Are you healthy today?** **Yes No** _____
12. **Do you live in a household with an infant less than 6 months old?** **Yes No** _____
13. **Have you ever had Guillain-Barré Syndrome** **Yes No** _____
14. **What is your age?** _____
15. **Do you use or are you exposed to tobacco?** **Yes No** _____

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

Manufacturers & Lot Numbers: (circle) _____ _____

Date Reviewed and Vaccinated **Nurses Initials**

☐ **Fluzone 0.5ml VIS: 7/26/11 Mfr: Sanofi Lot #: UH456AA Route: IM Site of Injection: LA RA LT RT**

☐ **Fluzone 0.5 ml VIS: 7/26/11 Mfr: Sanofi Lot #: UH462AB Route: IM Site of Injection: LA RA LT RT**

☐ **Fluzone 0.5ml VIS: 7/26/11 Mfr: Sanofi Lot #: UH462AC Route: IM Site of Injection: LA RA LT RT**

☐ **Fluzone 0.5ml VIS: 7/26/11 Mfr: Sanofi Lot #: UH478AC Route: IM Site of Injection: LA RA LT RT**

☐ **PF Fluzone 0.5ml VIS: 7/26/11 Mfr: Sanofi Lot #: U4124AA Route: IM Site of Injection: LA RA LT RT**

☐ **PF Fluzone 0.5 ml VIS: 7/26/11 Mfr: Sanofi Lot #: Route: IM Site of Injection: LA RA LT RT**

☐ **FluMist 0.2ml VIS: 7/26/11 Mfr: MedImmune Lot #: 501092P Route: IN**

☐ **FluMist 0.2ml VIS: 7/26/11 Mfr: MedImmune Lot #: 501098P Route: IN**