

UMDHU Respiratory Influenza Family Administration Form

Parent's Name: <i>Please Print</i>	Address (Street or PO Box):	City:	State:	Zip Code:
Mother's:				
Father's:				
Primary Phone:				

Primary Policy Holder Information

Last Name:	First Name:	Middle Name:
Date of Birth:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Policy Holder Relationship to Client:
Insurance Company Name:		Telephone Number:
Address:	City:	State: Zip Code:
Policy #	Group # (if applicable)	

Secondary Policy Holder Information if Applicable

Last Name:	First Name:	Middle Name:
Date of Birth:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Policy Holder Relationship to Client:
Insurance Company Name:		Telephone Number:
Address:	City:	State: Zip Code:
Policy #	Group # (if applicable)	

Client #1 Name		Client #2		Client #3		Client #4	
First:	MI:	First:	MI:	First:	MI:	First:	MI:
Last:		Last:		Last:		Last:	
Date of birth:	Age:	Date of birth:	Age:	Date of birth:	Age:	Date of birth:	Age:
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino <input type="checkbox"/> Unknown	
Birth State:		Birth State:		Birth State:		Birth State:	
Race:		Race:		Race:		Race:	

THESE QUESTIONS are used to determine if children 18 years of age or younger qualify for the federally funded immunization program titled Vaccine for Children (VFC)

1. Does your child have private health insurance?
2. Does your private health insurance cover immunization?
3. Is your child covered by Healthy Steps?
4. Is your child Native American or Alaskan Native?
5. Is your child covered by the Caring for Children Program?
6. Is your child enrolled in Medicaid?

Is Medicaid: Primary Insurance or Secondary Insurance

Medicaid Number

Client #1	Client #2	Client #3	Client #4
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Pri <input type="checkbox"/> Sec	<input type="checkbox"/> Pri <input type="checkbox"/> Sec	<input type="checkbox"/> Pri <input type="checkbox"/> Sec	<input type="checkbox"/> Pri <input type="checkbox"/> Sec

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

OVER →

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

Administered: Manufacturers & Lot Numbers: (circle) Nurses Initials _____ Date Reviewed and Vaccinated: _____

Client # _____ Fluzone 0.5ml Mfr: Sanofi Lot #: UH456AA Route: IM Site of Injection: LA RA LT RT

Client # _____ Fluzone 0.5 ml Mfr: Sanofi Lot #: UH462AB Route: IM Site of Injection: LA RA LT RT

Client # _____ Fluzone 0.5ml Mfr: Sanofi Lot #: UH462AC Route: IM Site of Injection: LA RA LT RT

Client # _____ Fluzone 0.5ml Mfr: Sanofi Lot #: UH478AC Route: IM Site of Injection: LA RA LT RT

Client # _____ Fluzone 0.5ml Mfr: Sanofi Lot #: U4124AA Route: IM Site of Injection: LA RA LT RT

Client # _____ PF Fluzone 0.25 ml Mfr: Sanofi Lot #: UT4176BA Route: IM Site of Injection: LA RA LT RT

Client # _____ FluMist 0.2ml Mfr: MedImmune Lot #: 501092P Route: IN

Client # _____ FluMist 0.2ml Mfr: MedImmune Lot #: 501098P Route: IN

√ VIS date: 7/26/11 given