Livingston County Health Department Vaccine Administration Record

LIVINGSTON COUNTY Health Department

NAME:	BIRTHDATE:	AGE:
_____ _____ _____ Last First Middle Int.		
ADDRESS:	TELEPHONE #:	
_____ _____ _____ _____ Street City State Zip Code		

Please answer the following questions:

1. Are you sick today? NO YES
2. Do you have any allergies to medications, food, latex or vaccine component? NO YES
3. Have you ever had a serious reaction to a vaccine in the past? NO YES

Please read and sign the statement of consent:

I have read or have had explained to me the information in the Vaccine Information Statement. I have had a chance to ask questions that were answered to my satisfaction. The information I have provided on this form is correct and true to my knowledge. I understand the benefits and risks of influenza vaccination and request that the vaccine be given to me or to the person named for whom I am authorized to make this request.
I acknowledge that a copy of the LCHD Notice of Privacy Practices has been made available to me.
I understand that information about the administered vaccine may be shared with local and state immunization registries.

X_____ Date _____

----------OFFICE USE ONLY----------

Clinic/Office: LCHD OTHER _____ Date Vaccine and VIS Given: _____

Vaccine Manufacturer: GSK SP SEQ Vaccine Lot#: _____

VIS Date: 8/15/19 Site given: R arm L arm Route: IM

Vaccine Administrator Signature: _____ Date: _____