DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Sussex County Health Unit	Seaford Public Health	Milford Health Unit	Kent County Health Unit	Hudson S.S.C.
544 S. Bedford St.	350 Virginia Ave	253 NE Front St	805 River Rd.	501 Ogletown Rd.
Georgetown, DE 19947	Seaford, DE 19973	Milford, DE 19963	Dover, DE 19901	Newark, DE 19711

Influenza Vaccination Administration Record

Patient's last name:	**First:**	**Middle:**	**Gender:** M ☐ F ☐ Trans ☐ Other ☐
Street address:			**Phone:**
City:		**State:**	**ZIP Code:**

Date of Birth: mm/dd/yyyy	**Age:**	**Hispanic Ethnicity:** Yes ☐ No ☐	**Haitian?** Yes ☐ No ☐

Race (**Check all that apply**): White ☐ Black ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐

Insurance: None ☐ Medicare ☐ Medicaid ☐ CHIP/DHCP* ☐ Private ☐_____

Medicaid/Medicare #	**MCO (if insured by Medicaid):** Highmark ☐ AmeriHealth ☐ Other ☐ _____

Please answer these questions:	**Yes**	**No**	**Clinician's Note**
Is the person to be vaccinated currently experiencing homelessness?	☐	☐	
Is the person to be vaccinated sick today?	☐	☐	
Has the person to be vaccinated ever had a serious allergic reaction to: • Influenza vaccine? • Eggs, egg proteins? • Natural rubber latex; or other substances? _____	☐	☐	
Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	
What is the weight of the person being vaccinated (best guess)?	___lbs		

My signature (below) means that I have been given a copy of the appropriate Vaccine Information Statement (VIS) and have read, or have had explained to me, information about the disease and the vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits as set forth in the VIS I was given, and I ask that the vaccine be given. Also, by signing below I hereby give my consent for DPH to bill my insurance based on eligibility for the vaccine received.

Signature _____**Date**_____

Signer's Name_____**Patient** ☐ **Parent** ☐**Guardian** ☐
Print Clearly

Do not write below this line. For Clinician use only.

NHS ___ **SHS** ___ **Clinic Location:** _____

Preparation/Route: (Check one)	**Dose:**	**Site:**	**Vaccination Date:**
☐ **Fluarix/Quad Inj. P-Free/IM** ☐ **FluLaval/Quad Inj. P-Free/IM** ☐ **Fluzone/Quad Inj. P-Free/IM**	**0.5ml** ___	**RA** ___ **RT** ___ **LA** ___ **LT** ___	_____

VIS Date:	**Date VIS Given:**	**Manufacturer (circle one):**	**Lot #:**	**Expiration Date:**
8/15/19		Sanofi GSK		

Clinician's Name (Print Clearly)	**Clinician's Signature:**	**License Title:**

☐ **VFC** – Child is under age 19 and **[*Use FED*]**
- ☐ Child is enrolled in Medicaid **or**
- ☐ Child is uninsured **or**
- ☐ Child is American Indian or Native Alaskan
- ☐ Child is enrolled in **Delaware Healthy Children's Program (DHCP*)** **[*Use FED*]**
- ☐ None of the above (child or adult) **[*Use STATE*]**

Doc # 35-05-20/20 8/25/20