First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_

SS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_ Race: \_\_\_\_\_\_ Hispanic or Non

Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Id Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If covered under parent/spouse’s plan (their info is needed)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please answer the following questions**

* Are you sick today (fever, cough, nausea/vomiting)? Yes or No
* Do you have a serious allergy to eggs (meaning you are unable to eat them)? Yes or No
* Do you currently have Guillain-Barre Syndrome (severe muscle weakness or paralysis)? Yes or No
* Ever had a serious reaction to any previous flu vaccine or any vaccine? Yes or No

**Please Read and Sign Below**

This record will be kept on file at the Macon Co. Health Dept. It will record when the vaccine was given, the name of the manufacturer, the lot number and injection site. I have read and been offered a copy of the **V**accine **I**nformation **S**tatement and have had the opportunity to ask questions and had them answered to my satisfaction. I understand the benefits and risk of the vaccine to be given and give my consent to receive the injection. I give consent for my insurance (if applicable) to be billed, **and if denied**, I understand that I am responsible for the payment in full. By signing below, I acknowledge that I have been offered a copy and/or read the HIPAA Privacy Act and agree to the statements above.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**High Dose (65 +) Date given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Sanofi Pasteur Lot # UT7715AA Exp. date: 06/30/2023 VIS date: 8/6/21 STICKER

Lot # UJ919AC Exp. Date: 06/30/2023

Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injection site: Rt Lt deltoid

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**FluBlok (18-64) Date given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Sanofi Pasteur Lot # UJ891AC Exp. date: 06/14/2023 VIS date: 8/6/21 STICKER

Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injection site: Rt Lt deltoid

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**Fluzone .5 (6M-40) Date given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Sanofi Pasteur Lot # UT7680NA Exp. date: 06/30/2023 VIS date: 8/6/21 STICKER

Lot #

Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injection site: Rt Lt deltoid thigh

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**Fluarix (19 +) 317 – NO Insurance Date given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

GSK Lot # Exp. date: VIS date: 8/6/21 STICKER

Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injection site: Rt Lt deltoid

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