Bartholomew County Health Department
2675 Foxpointe Drive Suite B, Columbus, IN 47203
812-379-1555 Opt 1

CHILDREN'S FLU VACCINE ADMINISTRATION FORM

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)" or the "Important Information Statement(s) for the disease(s) and vaccine(s) checked below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and the risks of the vaccine(s) requested and ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request.

Confidential Information:

Last Name:	First Name:	Middle Name:	DOB:	Age:	Gender: ○ Male ○ Female
Physician Name:	Medicaid #:	County of Residence:	Birth State:	Race:	Hispanic Origin: ○ YES ○ NO
Address:	City:	State:	Zip:	Home Phone: ( )	
Guardian Last Name:	First Name:			Email:	

I agree to allow information about all vaccinations given to me or to the person for whom I am authorized to consent, to be released to school and/or medical care providers to avoid the administration of unnecessary vaccinations and to ascertain immunization status.

☐ YES ☐ NO

_____

Signature of person to receive vaccine or person authorized

	YES	NO	DON'T KNOW
1. Is the child sick today?			
2. Does the child have allergies to medications, food, or any vaccine?			
3. Has the child ever had a serious reaction after receiving a vaccination?			
4. Has the child ever had Guillain-Barre syndrome?			

√	Vaccine(s) given today	Lot# / Manufacturer	Dose	Site Route	VIS Date	Notes:
	VFC					
	Influ, Inject, Quad Pres. Free (6-35 months)			IM		
	Influ, inject, Quad, Pres Free (36 + months)			IM		
	PRIVATE					
	Influ, Inject, Quad Pres. Free (6-35 months)			IM		
	Influ, Inject, Quad Pres. Free (36 + Months)			IM		

Nurses Signature

RN Date