

2009-2010 Vaccine Administration Record

Information about the person to receive vaccine (please print): ***Required Fields**

Name: (Last, First, MI)*		DOB: (MM/DD/YY)*	Sex: (Circle)* M F
Address:*			
City:*	State:*	Zip:*	Phone:* ()

INSURANCE INFORMATION: *Include the prefix and suffix with the insurance ID number, if applicable.*

Insurance Company:*	Member ID #:*	Group ID #:
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If Patient is not the Subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*		Subscriber's DOB:	Sex: (Circle)* M F
Subscriber's Address: * (If different from address above)			
City:*	State:*	Zip: *	Phone:* ()
Patient Relationship to Subscriber:* (Circle) Spouse Child Other			

OTHER INSURANCE INFORMATION: *Include the prefix and suffix with the insurance ID number, if applicable.*

Insurance Company:*	Member ID #:*	Group ID #:
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I give permission for my insurance company to be billed.

X _____
(Signature of patient, parent or legal guardian)

Date: _____

For Clinic/Office Use: Contact Person: _____ Amy Ewing _____ Phone Number: 978-983-8655 _____

Vaccine Name: * (Circle)	Vaccine Manufacturer:	Vaccine Lot Number:	Date Vaccine Administered:*	Vaccine Type: * (Circle)	Injection Site: * (Circle)	Injection Route: * (Circle)
H1N1 Seasonal Influenza			(MM/DD/YY)	Dose #1 Dose #2	Right Arm Left Arm Right Leg Left Leg	Intramuscular Intranasal

Clinic Site Name: Methuen Health Department Site PIN# : 11118

Clinic Address: 90 Hampshire St., Methuen, MA, 01844 Vaccine Administrator: _____

Date Vaccine Information Statement (VIS) given: _____ Date on VIS: 10/2/09

Signature of Vaccine Administrator: _____ Date: _____