pacific medical centers

2018-2019 Influenza Vaccine
Flu Clinic Administration Record

PLEASE PRINT		
Patient's Last Name		Patient's First Name
Patient's Age	Patient's Date of Birth	Is the patient a: ☐ Current PMC Patient ☐ Non-PMC Patient
Print Guardian's Name (if applicable)		Guardian's Signature_____Date_____

PLEASE ANSWER THESE QUESTIONS for the patient receiving flu vaccine today:	YES	NO
1. Are you sick today?		
2. Are you allergic to eggs or to a component of the vaccine?		
3. Have you ever had a serious medical or allergic reaction to a flu vaccination?		
4. Do you have a history of Guillain-Barré syndrome?		

FOR PMC FLU CLINIC USE

PMC Supplied Vaccines	VFC Supplied Vaccines
☐ **Fluzone** (19yrs and older)	☐ Fluzone 0.25ml PFS, (6-35mos)
☐ **Fluzone High-Dose** (65yrs and older)	☐ Fluzone MDV, 3-18 years
☐ **Flublock** (19yrs and older & allergy to eggs)	☐ Fluarix / FluLaval 0.5ml PFS

Lot Number/Exp date:

Place Syringe Label Here

IM Injection Site:

Deltoid: ☐ Left / ☐ Right

Anterolateral Thigh: ☐ Left / ☐ Right

Print Name & Title of Vaccine Administrator:_____ **Date Administered:**_____

Uninsured adult patients (19yrs and older) will be responsible for payment at the time of service.

Payment Information: $50 By: CASH CHECK CREDIT CARD

Received By:_____

Patient Name:

DOB:

MRN:

Clinic Location:

**Not part of the patient's permanent record. Once vaccine information is entered into EPIC, send forms to CBS via interoffice mail (red envelope). CBS can retain forms for 3 months for billing and insurance purposes.*