pacific medical centers
"Simply the Right Care"

# 2019-2020 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** 0.5ml single dose, (6mos-18yrs) |
| ☐ **Fluzone High-Dose** (65yrs and older) | ☐ **Fluzone MDV**, (3-18 years) |
| ☐ **Flublock** (19yrs and older & allergy to eggs) | ☐ **Flulaval** 0.5ml single dose, (6mos-18yrs) |
| | ☐ **Flumist** 0.2 ml, single dose (2yrs-18 years) |

**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 (self-pay) patients will be responsible for payment at the time of service.**

**Payment Information:** CASH CHECK CREDIT CARD

**$23.44** for children ages 6 months–18 years / **$45** for ages 19-64 years / **$74** for ages 65 and older

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.*