HD01148F (revised 6/2009)

pennsylvania
DEPARTMENT OF HEALTH

INFLUENZA VACCINE RECORD

Information About Person To Receive Vaccine (Please Print)

_____ _____ _____
Last Name First Name Middle Name

_____ _____
Mailing Address Apt/Suite

_____ _____ _____ _____
City State Zip County

_____ _____ _____ _____ _____
Date of Birth **Age** Area Code Phone Number Parent/Guardian Name

GENDER

☐ **Male** ☐ **Female** ☐ **Unknown**

SPOKEN LANGUAGE

☐ **Cambodian** ☐ **Korean**
☐ **Chinese** ☐ **Laotian**
☐ **English** ☐ **Portuguese**
☐ **French** ☐ **Refused**
☐ **German** ☐ **Russian**
☐ **Haitian Creole** ☐ **Spanish**
☐ **Hmong** ☐ **Unknown**
☐ **Italian** ☐ **Vietnamese**
☐ **Other (Specify):**

_____

RACE (Check all that apply)

☐ Aleut ☐ Japanese
☐ Arabian ☐ Korean
☐ Asian Indian ☐ Laotian
☐ **Black** ☐ Other Asian or Pacific Islander
☐ Cambodian ☐ Refused
☐ Chinese ☐ Samoan
☐ Eskimo ☐ Thailander
☐ Filipino ☐ Unknown
☐ Guamian ☐ Vietnamese
☐ Hawaiian ☐ **White**
☐ Indian
☐ **Other (Specify):**

_____

HISPANIC ORIGIN

☐ Cuban ☐ Mexican
☐ **Non-Hispanic** ☐ Puerto Rican
☐ Refused ☐ South or Central American
☐ Unknown
☐ Unknown Hispanic
☐ **Other (Specify):**

_____

HEALTH PLAN

☐ CHIP ☐ No Insurance
☐ Medicaid ☐ Private Insurance
☐ Medicare ☐ Unknown
☐ **Other (Specify):**

_____

DO YOU HAVE DIABETES?

☐ **Yes** ☐ **No**

COAL MINER

☐ Active Miner ☐ Retired Miner ☐ Miner's Spouse

INACTIVATED INFLUENZA VACCINE

Did you ever have a reaction to a previous dose of flu vaccine?	☐ Yes	☐ No
Do you have a serious allergic reaction to eggs?	☐ Yes	☐ No
Do you have a history of Gullain-Barre Syndrome (a severe paralytic illness)?	☐ Yes	☐ No

I have read or have had explained to me the information in "Vaccine Information Statement (VIS): Inactivated Influenza Vaccine: WHAT YOU NEED TO KNOW." I have had a chance to ask questions. Any questions were addressed to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

X _____ _____
Signature/Signature of Parent or Guardian of minor **Date**

For Clinic Use Only

Vaccination Date: _____

Dosage Volume: _____

Injection Site: **RD** **LD**

Route: IM

Manufacturer: _____

Lot Number: _____

Date of VIS : _____

_____
Signature of Vaccine Administrator

_____
Signature Date