

# VACCINE ADMINISTRATION RECORD ♦ NOVEMBER 2009

**1. Complete the highlighted areas below – Please Print Clearly**

**Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_  
LAST NAME FIRST NAME MI

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:**  Female  Male

**Town of Residence:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
P.O. BOX OR RR TOWN STATE ZIP

**Island Physician or Clinic:** \_\_\_\_\_

*I am not allergic to chicken eggs, chicken, chicken feathers or dander; I am not allergic to Thimerosal (a mercury-based preservative); I do not have a history of severe allergic reactions to vaccines.*

*Signature of person receiving the vaccine or that person's guardian:*

\_\_\_\_\_ Date: \_\_\_\_\_

**2. Complete this section if you are covered by Medicare Part B or another health insurance plan and sign again below.**

**Medicare Number:** \_\_\_\_\_ Part B?  YES  NO

I give permission for this agency and/or the Massachusetts Department of Public Health to bill Medicare Part B on my behalf for influenza and/or pneumococcal vaccine.

\_\_\_\_\_ Date: \_\_\_\_\_  
*Your Signature*

**Please complete the Questionnaire on back →**

**Below this Line for Clinic Use Only**

Vaccine	Type of Vaccine	Date given mo/da/yr	Dose	Route	Site* RA - LA RT - LT	Vaccine		Information Statement		Vaccine Admin. Initials
						Lot # Exp. Date	Mfr	Date on VIS	Date Given	
Influenza	Flu		0.5ml	IM				8/11/09		
Pneumonia	PPV23		0.5ml	<input type="checkbox"/> SC <input type="checkbox"/> IM				4/16/09		
Tetanus/ diphtheria	Td		0.5ml	IM				11/18/08		
						<i>Signature of Vaccine Administrator</i>				

\* Site given: RA = Right Arm, LA = Left Arm, RT = Right Thigh, LT = Left Thigh.