GRAHAM COUNTY DEPARTMENT OF PUBLIC HEALTH

Name: _____ _____ _____ _____
Last Name First Name MI Maiden Name

Sex: ☐ Male ☐ Female

Race: ☐ White ☐ American Indian ☐ Native Alaskan ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Island ☐ Black

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Birth date: _____/_____/_____ SSN#_____

Address_____

City_____ _____State_____ Zip Code _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Please write your Medicare/Medicaid number <u>exactly</u> as it appears on your card.
Medicaid #
Medicare # _____ BSBC ID#_____

Mother's Maiden Name: _____

Graham County Department of Public Health

By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for Graham County Department of Public Health.
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

_____ _____
Signature of patient or parent/legal guardian/legally responsible person Date

_____
Description of relationship to patient

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GRAHAM COUNTY DEPARTMENT OF PUBLIC HEALTH

Eligibility: ☐ American Indian/Alaskan Native ☐ Medicaid ☐ Not Insured ☐ NC Health Choice ☐ Insured

FLU ADM. 90471/G0008 V04.81 PNEUMONIA 90732 ADM. G0009 V03.82

Vaccine	Trade Name	Lot #	VIS Pub Date	Date VIS Presented and Reviewed	Body Route	Body Site*	Dose (mL)	State/ Purch.	Entered NCIR / HIS
Influenza Nasa1 90672			**07/26/2013**		**IN**	**BN RN LN**	**0.2**	**S P**	/
Influenza/ Injection 90655/90656 90657/90658 Q2037/Q2038			**07/26/2013**		**IM**	**RVL LVL RD LD**	**0.25 0.5**	**S P**	

*RVL=right vastus lateralis, LVL=left vastus lateralis, RD=right deltoid, LD=left deltoid, BN=both nares, RN=right naris, LN=left naris

Screening Questions

1. Is person being vaccinated sick today? YES NO
2. Does person being vaccinated have an allergy to eggs or to a component of the vaccine? YES NO
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? YES NO
4. Has the person to be vaccinated ever had Gullain-Barre syndrome? YES NO

Form completed by:_____ Date:_____

Form reviewed by:_____ Date:_____