Appendix 1. Vaccine Administration Record

Information about the person to receive vaccine (please print): ***Required Fields**

Name: (Last, First, MI)*			**DOB: (MM/DD/YY)***	**Sex: (Circle)*** **M F**
Address:*				
City:*	**State:***	**Zip:***	**Phone:*** **( )**	

INSURANCE INFORMATION: Include the prefix and suffix with the insurance ID number, if applicable.

Insurance Company:*	**Member ID #:***	**Group ID #:**

If Patient is not the Subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*			**Subscriber's DOB:**	**Sex: (Circle)*** **M F**
Subscriber's Address:* (If different from address above)				
City:*	**State:***	**Zip: ***	**Phone:*** **( )**	
Patient Relationship to Subscriber:* (Circle)	**Spouse**	**Child**	**Other**	

OTHER INSURANCE INFORMATION: Include the prefix and suffix with the insurance ID number, if applicable.

Insurance Company:*	**Member ID #:***	**Group ID #:**

I give permission for my insurance company to be billed.

X_____ Date:_____
(Signature of patient, parent or legal guardian)

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For Clinic/Office Use: Contact Person: Ro Sarro RN/BSN, Public Health Nurse Phone Number: 617-846-1740 ext 130

Vaccine Name:* (Circle)	**Vaccine Manufacturer:**	**Vaccine Lot Number:**	**Date Vaccine Administered:***	**Vaccine Type:* (Circle)**	**Injection Site: * (Circle)**	**Injection Route:* (Circle)**
H1N1 **Seasonal Influenza**			**(MM/DD/YY)**	**Dose #1** **Dose #2**	**Right Arm** **Left Arm** **Right Leg** **Left Leg**	**Intramuscular** **Intranasal**

Clinic Site Name: _Winthrop Public Health Department_____ Site PIN#: 11812___

Clinic Address: 1 Metcalf Square Rm. 5, Winthrop, Ma 02152

Vaccine Administrator:_____

Date Vaccine Information Statement (VIS) given:_____ Date on VIS:_____

Signature of Vaccine Administrator:_____Date:_____