Nemaha County Community Health Services
VACCINE ADMINISTRATION RECORD

I have been offered a copy of the "Vaccine Information Statement" (VIS) checked below and the Nemaha County Community Health Services' Notice of Privacy Practices. I have read, or had explained to me, the information in the VIS. You may release this information to my doctor. All Information is Confidential. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below. **I ask that the vaccine(s) checked below be given to me or to the person named above for whom I am authorized to make this request**.

☒ Influenza

PATIENT INFORMATION

Name _____ **Date of Birth:** _____ **Age**_____
(First) (Last) (MI)

Gender: ☐ Male ☐ Female ☐ Self-describe:_____

Mailing Address _____ **City** _____ **State** _____ **Zip Code** _____

Phone Number _____ **Primary Care Physician:** _____

HEALTH SCREENING

1. Is the patient to be vaccinated currently sick or experiencing high fever?	Yes	or	No
2. Does the patient have allergies to medications, food, a vaccine component or latex?	Yes	or	No
3. Is the patient immunocompromised or is the patient on a medicine that affects their immune system?	Yes	or	No
4. Has the patient had a serious reaction to a vaccine in the past?	Yes	or	No
5. Has the patient received vaccinations in the past 4 weeks? If yes:	Yes	or	No
6. Influenza Only: If the person receiving a flu shot is under 9 years of age, did they receive a flu shot in the past?	Yes	No	N/A

7. Check all that apply to the patient:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)
- ☐ History of heparin-induced thrombocytopenia
- ☐ Have a history of thrombosis with thrombocytopenia syndrome
- ☐ Have a history of Guillain-Barre Syndrome

HEALTH INSURANCE INFORMATION
(Skip if front and back copy of insurance card is attached)

1. Do you have health insurance? Yes No
2. Does your insurance cover immunizations? Yes No

Name of the Policy Holder (exactly as it appears on the insurance card) :_____

- Medicare: ID #_____
- Medicaid/Kancare: ID #_____ Healthy Blue Sunflower United Healthcare
- Private Insurance: ID #_____ Group #_____
  Insurance Co: _____ Insurance Co Address: _____
  Relationship to insured: Self Spouse Child Other:_____

By signing below I agree, Nemaha County Community Health Services, Inc. can bill my Insurance for any services rendered as applicable. I understand I will be responsible for any services provided which my Insurance does not cover.
I certify that the above information is correct to the best of my knowledge.

Recipient/Parent/Guardian Signature _____ Date_____

PROVIDER INFORMATION (clinical use only)					
Vaccine Provider: Nemaha County Community Health Services			Clinic Site:		
Street Address: 1004 Main Street	State KS	Zip Code 66534	Street Address:	State	Zip Code

FOR CLINICAL USE ONLY

Vaccine	Dose	Ext.	Site	Route	VIS Date	Mfr./Lot #	Exp. Date
Private Influenza	**1 2**	**RT** **LT**	Deltoid Vastus Lat	IM 0.5ml	01/31/2025	**Sanofi**	
Public Influenza	**1 2**	**RT** **LT**	Deltoid Vastus Lat	IM 0.5ml	01/31/2025	**Sanofi** UT8770NA (PFS) UT8792MA (PFS)	06/30/26

Signature and Title of Vaccine Administrator **Date**