2021-2022 INFLUENZA VACCINE ADMINISTRATION RECORD - MIST

The information contained within this record is being maintained to monitor immunization needs in order to prevent disease. If personal information is requested and not provided, immunization services may be denied. This information is private and will not be shared with anyone except the Minnesota Department of Health, licensed health care professionals such as doctors and nurses, health insurers, county public health agencies, or licensed health care facilities such as hospitals or nursing homes in order to assess and/or provide immunization services.

PLEASE PRINT	INFORMATION ABOUT THE PERSON RECEIVING VACCINE			
FIRST NAME:	**LAST NAME:**			**MI:**
DATE OF BIRTH:	**AGE:**		**GENDER:** M F	**PHONE NUMBER:**
ADDRESS:	**CITY:**	**STATE:** MN	**ZIP CODE**	**MOTHER'S MAIDEN NAME:**

CLINIC SITE ADDRESS: (please circle)

Aitkin HS **306 2nd St NW** **Aitkin, MN 56431**	**Ripplside Elementary** **225 2nd Ave SW** **Aitkin, MN 56431**	**McGregor School** **148 South 2nd St** **McGregor, MN 55760**	**Hill City School** **500 Ione Ave** **Hill City, MN 55748**

Grade:	**Teacher:**	
Insurance provider:	**Policy number:**	**Group number:**

VACCINE PRESENTATION: Please check your preferred option.

Flu Mist*_____ Injection_____ No preference_____

***as supplies last**

ANSWER THE QUESTIONS BELOW ABOUT THE PERSON TO RECEIVE THE VACCINE		
1. Have you ever had a flu shot before?	Yes	No
2. Do you have any serious allergies? Please list:_____	Yes	No
3. Have you ever had any problem or allergic reaction to a flu shot?	Yes	No
4. Are you sick today or have a fever?	Yes	No
5. Do you have allergies to eggs or a component to the flu vaccine?	Yes	No
6. Have you ever had Guillian Barre` Syndrome (a severe paralytic illness, also called GBS)?	Yes	No
FLUMIST QUESTIONS		
7. Have you been vaccinated with any vaccine in the past 4 weeks? If yes, what and when: _____	Yes	No
8. Do you have any of the following: Asthma, diabetes or any other type of metabolic disease, disease of the lungs, heart, kidneys, liver, nerves or blood, on aspirin or aspirin-containing therapy?	Yes	No
9. Do you have a weakened immune system because of AIDS/HIV, cancer treatments, treatment with steroids?	Yes	No
10. Are you pregnant or could become pregnant in the next month?	Yes	No
11. Are you or have you been on an antiviral medication in the past 48 hours	Yes	No
12. Do you have close contact with a person who is hospitalized and in a protected environment?	Yes	No
13. Is the person to be vaccinated younger than 2 years OR older than 49 years?	Yes	No

THIS CLINIC IS PROVIDED FOR YOU BY: PUBLIC HEALTH OF AITKIN COUNTY HEALTH AND HUMAN SERVICES, 204 1ST STREET NW, AITKIN, MN 56431

"I have been given a copy of and have read information about the disease and vaccine I have requested. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or to the person named above. If the person named above is a minor child or unable to sign for him/herself, I attest that I am his parent, authorized representative or legal guardian and may legally provide consent for immunizations. I give consent to ACH&HS to bill my insurance for these vaccines. If my employer is paying for my vaccine, I agree that they may receive my name and the fact that I have received the vaccine. I agree to pay for the vaccination if my insurance does not cover it."

SIGNATURE: _____ Date:_____

*****FOR CLINIC USE ONLY*****

We Bill:
Medicare, UCare, MA, any MN Healthcare program,

Blue Cross Blue Shield, Medica and Health Partners,
Please check below if they pay cash or check.

- ❑ Cash
- ❑ Check #_____

IIV Injectable: $
High-Dose: $
FluMist: $

✓only one box	State Supplied Vaccine Eligibility Screening	0-18 yrs	19+ yrs
	Has insurance that covers the cost of all vaccines	Private	Private
	Has insurance that does not cover vaccines until a deductible has been met	Private	Private
	Has no insurance	MnVFC	UUAV
	Has Minnesota Health Care Program (MHCP) insurance: MA, PMAP, or MinnesotaCare	MnVFC	Private
	American Indian or Native Alaskan	MnVFC	Private
	Has insurance that does not cover vaccines	MnVFC	UUAV
	Has insurance covering only selected vaccines (MnVFC-eligible for non-covered vaccines only)	MnVFC	UUAV
	Has insurance that caps services at a certain amount and that amount has been reached	MnVFC	UUAV

VACCINE	LAIV	INFLUENZA	INFLUENZA	INFLUENZA	LAIV
DATE SHOT/VIS GIVEN					
DATE ON VIS	08/06/21	08/06/21	08/06/21	08/06/21	08/06/21
VACCINE NAME	FLUMIST **(2-49yrs)**	Fluad Quad **(65yrs+)**	Afluria **0.25 mL(6mos-35mos) 0.5mL (3years +)**	FluLaval **(6mos – 18yrs)**	FLUMIST **(2-18yrs)**
MANUFACTURER	AstraZeneca	Seqirus	Seqirus	GSK	AstraZeneca
SOURCE	PRIVATE	PRIVATE	PRIVATE	MnVFC/UUAV	MnVFC
LOT NUMBER	NH2013 NH2014	312832 312853	P100352329 P100353146	2579B	NH2451
EXPIRATION DATE	12/20/21 12/29/21	05/11/2022 06/17/2022	05/27/2022 06/08/2022	06/30/2022	12/07/21
ROUTE	NASAL	IM	IM	IM	NASAL
SITE	NARES	LDT RDT OTHER_____	LDT RDT OTHER _____	LDT RDT OTHER_____	NARES
PUBLIC HEALTH NURSE SIGNATURE (Initial in white box) Brea Hamdorf, PHN Liz Short, PHN Naomi Larson, PHN Erin Melz, PHN Bonnie Carlson, RN Cynthia Bennett, PHN					