



DISTRICT HEALTH DEPARTMENT NO. 4

of Household Members
12 and older _____
Under 12 _____
(Complete once per household)

VACCINE ADMINISTRATION RECORD

The doctor or clinic may keep this record in your medical file or your child's medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

"I have read or have had explained to me the information on the VIS about Influenza, Pneumococcal and/or Tetanus vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza, pneumococcal and/or tetanus vaccine and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request"

- Tetanus
- Flu
- Pneumococcal

Medicaid # _____ Private Pay _____

Medicare # _____ HMO Contract # _____

Name of Medicare Part D HMO _____

Information about person to receive vaccine (Please print)				
Name: Last	First	Middle Int.	Birthdate	Age
Address:		City	County	State
				Zip
Telephone Number				
X _____			Date: _____	
Signature of person to receive vaccine or person authorized to make the request (parent or guardian)				

I have checked the above information for completeness _____
Secretary initials

HIPPA Signed _____
Secretary initials

<i>Influenza</i>	<i>Pneumococcal</i>	<i>Tetanus</i>
VIS Date	VIS Date	VIS Date
Clinic Ident.	Clinic Ident.	Clinic Ident.
Date Vaccinated:	Date Vaccinated	Date Vaccinated
Manufacturer and Lot No.	Manufacturer and Lot No	Manufacturer and Lot No
Site of Injection	Site of Injection	Site of Injection
Signature/Title	Signature/Title	Signature/Title

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state federal regulations to implement policies and procedures to safeguard the privacy of your health information. We are required by state and federal regulators to abide by the privacy practices described in the Notice provided to you including any future revisions that we may make to the Notice as may become necessary or as authorized by law.

The effective date of this Privacy Notice is April 14, 2003.

We reserve the right to change our Privacy Notice at any time and to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise or change our Privacy Notice, we will post a copy of the new or revised Notice in our main lobby. You may obtain a copy of the new/revised privacy Notice from any of our offices or download a copy from our website www.dhd4.org.

I have received a copy of District Health Department No. 4's Privacy Practices, and have been given an opportunity to review the Notice and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations and am confident District Health Department No. 4 is committed to protecting health information.

Client/Authorized Representative

Date

Print Client's Name