GALLIA COUNTY GENERAL HEALTH DISTRICT
VACCINE ADMINISTRATION FORM

Client Information

Last Name	First Name	M.I.	Date of Birth	Age	Sex
			/ /	***	☐ Male ☐ Female

Address	City/Township	State	Zip	County
	/			GALLIA

Phone (if age 17 and under, phone of parent/guardian)	Parent/Guardian Name (if client is age 17 and under)	Race (for statistical use only)	Hispanic?
- - -		☐ Asian Pacific ☐ White ☐ Other ☐ Black ☐ Native American	☐ Yes

Answer a few short questions so we can make sure that the vaccine can be given today

☐ Yes ☐ No	Is the client sick today?
☐ Yes ☐ No	Is the client allergic to latex, medications, food, or any vaccines? IF YES, list the allergies:_____
☐ Yes ☐ No	Does the client have a history of Guillain-Barre syndrome?
☐ Yes ☐ No	Is the person receiving the flu vaccine 8 years old or under? IF YES, how many doses did the child receive the FIRST year they received the flu vaccine? ☐ 1 ☐ 2 ☐ Not sure
☐ Yes ☐ No	Has the client had other vaccines or anti-virals in the last 30 days? IF YES, list the vaccines: _____
☐ Yes ☐ No	Does the client have a history of wheezing and/or asthma?
☐ Yes ☐ No	Is the client pregnant or could possibly find out that she is pregnant in the next month?
☐ Yes ☐ No	Does the client have or has had any medical conditions (i.e. Diabetes; Cancer; Seizure; Heart Disease;Stroke; HIV/AIDS; Kidney Disease; Auto immune disorder; other)? If yes:_____
☐ Yes ☐ No	Is the client taking long-term aspirin therapy or aspirin-containing therapy?
☐ Yes ☐ No	Is the client around an infant 6 months of age or younger?
☐ Yes ☐ No	Is the client a healthcare worker?

☐ Medicaid ☐ Medicare ☐ Private insurance ☐ No health insurance ☐ Under-insured (vaccinations not covered)

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY # / Member Id #
NAME OF INSURED	GROUP #

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY # / Member Id #
NAME OF INSURED	GROUP #

Client Consent (or Parent/Guardian Consent for clients age 17 & under) - read and sign/date below.

I was given an explanation about the diseases and vaccines. I had the opportunity to ask questions that were answered to my satisfaction and/or received a Vaccine Information Sheet. I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or the person named above for whom I am authorized to make this request. I hereby consent that the Local Health Department (LHD), or designee, from whom I received the vaccination can bill my insurance, if applicable. I understand I am financially responsible for any fees not covered by my insurance company. I authorize the release of this record to the Ohio Department of Health Immunization Program. I hereby acknowledge receipt of the LHD Notice of Health Information Privacy Practice and give permission to release my immunization record to my doctor or agency/school. If indicated on this form, I authorize the LHD or designee to change my account. For clients age 17 and under, parent and/or guardian consents to allow client to receive vaccine without parent and/or guardian present.

SIGN Name X _____ Date_____

Office Use Only

Vaccine Administered Informaion

SC = subcutaneous IM = intramuscular ID = intradermal IN = intranasal

Date	Vaccine Name	Vaccine Lot #	Mfg	RA	LA	RT	LT	Nose	Dose (check box) 0.7 mL	0.5 mL	0.3 mL	0.25 mL	0.2 mL	0.1 mL	Vaccinator Initials

Clinic site:

VIS: ☐ Covid 01/31/2025 ☐ Flu 01/31/2025 ☐ PCV 05/29/2025 ☐ PPSV23 05/29/2025