

## Influenza Immunization Administration Record

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  M  F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

ASIIS #: \_\_\_\_\_

**Parent, Guardian, or vaccine recipient - Please read and initial.**

Initials	
	<b>Statement 1:</b> I have read or have had explained to me the information contained in the Vaccine Information Statement (VIS) Influenza. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine and request that the vaccine indicated on this form be given to me or the person named on this health record for who I am authorized to make this request.
	<b>Statement 2:</b> I agree to allow the health care provider giving vaccinations to release information about all vaccinations given to me, or to the person for whom I am authorized to consent, to the Arizona State Immunization Information System (ASIIS), other health care providers and schools in order to avoid receiving unnecessary vaccinations and to provide information about what immunizations have been received. I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request.
	If I do not wish this record to be included in ASIIS, I have the option of crossing out the above boxed statement and initialing it. I understand that by making this decision, I will not have access to my immunization records (in ASIIS) in the future for schools, college attendance, future jobs/employment, military, etc.

Vaccine	Date Vax & VIS Given	Signature of Person to receive vaccine or person authorized to make request**	Vaccine Manufacturer	Vaccine Lot Number	Enter site used, i.e. IM or nasal, etc.	Name/Title of Vaccine Administrator	Date of VIS	VFC (Code Below)
Influenza								
Influenza								
Influenza								
Influenza								
Influenza								
Influenza								
Influenza								
Influenza								
Influenza								

Vaccines for Children (VFC) Codes: 1 = Private Insured (not VFC eligible) 2= AHCCCS 3 = Uninsured (self pays) 4 = American Indian or Alaska Native (AI/AN) 5= Under-Insured (Deputized Providers Only) 6 = KidsCare

\*\*With the recent change to our child care and school rules there is a slight change in documenting parental requests (consent) for their child's vaccination.

The rule requires documented written, photographic, electronic or other permanent form of parental request of vaccination.

This means that a hard signature is no longer the requirement. Providers can determine which documentation from the list above is most appropriate for their office.