

Influenza Clinic Screening & Administration Record

Bloomington Public Health, 1900 W. Old Shakopee Rd., Bloomington, MN 55431

Last Name (Print)	First Name (Print)	MI	Birthdate	Age	Gender M F
Street Address	City	MN	Zipcode	Daytime Phone	
Medicare #	Insurance Company	ID #		Group #	
Policyholder's Name	Policyholder's Birthdate	Relationship to Shot Recipient		Race	Ethnicity

Please answer the following and if there is a YES response, please talk with the nurse before receiving the vaccination.

- YES NO
- Does the person requesting this vaccine have a severe allergy to eggs, gelatin, gentamicin, Monosodium Glutamate, thimerosal or latex?
- Has the person requesting this vaccine ever needed immediate medical attention after a vaccination?
- Is the person requesting the vaccine ill with fever (100 F or higher), productive cough, muscle aches or other?
- Has the person requesting the vaccine ever had Guillain-Barre syndrome (French polio) after receiving a vaccine?

- I have been given an information sheet about the influenza vaccine and any other vaccine that I am requesting. I have had the opportunity to read this information or have it explained to me. I have been provided with the opportunity to ask questions about the benefits and risks of these vaccines.
- I authorize the release of information necessary to process this insurance claim and I authorize payment to the City of Bloomington for these vaccination services.

If you object to having your immunizations entered into the statewide registry, please check this box.

Client Signature	Date
-------------------------	-------------

For nurse use only:

Fluzone quadrivalent 0.5 ml IM (6 months & older)	RD _____ LD _____	Mftr/Lot# _____	SP _____	exp. 6/30/21
FLUBLOK Quadrivalent 0.5 ml IM (65 & older) (approved for 18 years & older)	RD _____ LD _____	Mftr/Lot# _____	SP _____	exp. 6/30/21
Hepatitis A Vaccine 1.0 ml IM (adult UUA V)	RD _____ LD _____	Mftr/Lot# _____	GSK EK59B	exp. 2/26/22
Tetanus/diphtheria/pertussis 0.5 ml IM	RD _____ LD _____	Mftr/Lot# _____	GSK 97NL3	exp. 6/5/21
Tetanus/diphtheria 0.5 ml IM	RD _____ LD _____	Mftr/Lot # _____	MB A121A	exp. 6/6/21
Nurse Signature/Title _____		Date _____		

**CITY OF BLOOMINGTON
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY**

Effective date: July 1, 2005
Amended: May 22, 2020

The Notice of Privacy Practices tells you how the City of Bloomington may use or disclose information about you. Not all situations will be described. The City of Bloomington is required to give you a notice of our privacy practices for the information we collect and keep about you.

I, _____ (Client's name), have been given a copy of the City of Bloomington's Notice of Privacy Practices and have had the chance to ask questions about how my information will be used.

Signature of Client or Personal Representative

Date

If signed by personal representative, relationship to client: _____

**This document can be made available in alternate formats that meet the
guidelines for the Americans with Disabilities Act (ADA).**

Contact the City of Bloomington:

Phone (952) 563-8900

MN Relay 711

Fax (952) 563-8997

For Office Use Only

We made the following efforts to obtain written acknowledgement of receipt of the Notice of Privacy Practices:

However, acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify):

