HAMILTON COUNTY
PUBLIC HEALTH

PREVENT. PROMOTE. PROTECT.

Attestation For Administration of Inactivated Injectable Influenza Vaccination

(Please PRINT Clearly)

Full Legal Name: ______________________________ **Date of Birth:** __________/__________/____________
MM DD YYYY

Phone Number: ____________________________ **Email Address:** _________________________________

Gender Identity (Check One):
☐ Male
☐ Female
☐ Self Describe: ____________________________

Address: ______________________________________
Street Address

____
City, State, Zip Code

Race: ☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

Ethnicity (Check One):
☐ Hispanic or Latino
☐ Not Hispanic or Latino

I have read, or had explained to me, the Vaccine Information Statement (VIS) about Inactivated Injectable Influenza Vaccination. I request that the Inactivated Injectable Influenza Vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary for public health reporting.

I have also been advised that I may report any adverse events that I may experience to my healthcare provider or to the Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 and www.vaers.hhs.gov.

I agree that it is my personal decision to receive this vaccine, and I give Hamilton County Public Health (HCPH) permission to administer this vaccine to me. By signing below, I further confirm that: I have read this Attestation or had it effectively communicated to me; any questions I may have had about it or the vaccine document(s) provided to me by HCPH have been answered to my satisfaction; I understand and accept all terms of this Attestation; I am the individual identified, above or their authorized personal representative; I am at least 18 years of age; and that I have signed this Attestation voluntarily.

Signature of Patient or Legal Guardian: ___________________________________ **Date:** ________________

Please complete the questionnaire on the back of this form.

FOR OFFICE USE ONLY *Vaccine Administration*	
Vaccination Site: ____________________________	Administered by (PRINT FULL NAME): ____________________
Vaccine Manufacturer: ____________________________	Administrator Signature: ____________________
Route/Site: ☐ IM - Left Deltoid ☐ IM - Right Deltoid	Date/Time Administered Dose: ____________________
☐ Other: _______________	Lot #: ________________ Expiration Date: ________________

26 August 2022

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Injectable Influenza Vaccination Screening Questions

Answer to the best of your ability

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason, we should not give you or your child inactivated injectable influenza vaccination today.

If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Question	Answer
Are you or the person to be vaccinated sick today?	☐ Yes ☐No
Does the person to be vaccinated have an egg allergy?	☐ Yes ☐No ☐Don't Know
Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	☐ Yes ☐No ☐Don't Know
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐ Yes ☐No
Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐ Yes ☐No ☐Don't Know

FOR OFFICE USE ONLY *Vaccine Screening*	
Did this person meet screening criteria for vaccination?	☐ Yes ☐No Staff Initials: _________

26 August 2022