



Adult Immunization Program Vaccine Administration Record

Name _____	Date of Birth _____
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Street Address, City, State, Zip _____

Telephone _____	Race _____	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Social Security Number _____	PATS ID Number (Staff Use Only) _____
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Preferred Method of Contact: Call Yes No Mail Yes No
 Preferred Phone/Address (if different from above) _____

Alternate Method of Contact:
 Emergency Contact: _____ Emergency Phone: _____

Medicare Card Number _____
(include alpha suffix)

Medicaid Card Number _____

Other Insurance: Company _____ Policy Number _____

Name and SS# of Policy Holder _____

The client Bill of Rights has been reviewed with the client or client's legal guardian? Yes

Billing Certification & Privacy Notice

By my signature below as parent, guardian or client, I request that payment of Medicare/Medicaid or other Third Party Insurance benefits be made on behalf of the South Carolina Department of Health and Environmental Control for any services provided me. Permission is also granted to DHEC to exchange medical or other confidential information as necessary to the Center For Medicare and Medicaid Services (CMS), its agents or other agents needed to determine these benefits for related services.

If applicable, I also agree to participate in treatment plans, assignment of insurance, Medicaid or Medicare benefits to DHEC for services rendered and to participate in payment for services as determined by specific program guidelines.

I acknowledge that I have been provided with a copy of DHEC's Privacy Notice. Patient refused notice? Yes

Signature (Client/Legal Guardian) _____ Date _____ Witness (if client signs with "X") _____ Date _____

VACCINE NAME	INJECTION SITE	INJECTION ROUTE	MANUFACTURER	LOT/CONTROL #	VIS FORM DATE
INFLUENZA (FLU)					
PNEUMOCOCCAL POLYSACCHARIDE (PPV23)					
TETANUS (Td)					

Signature and Title of Person Administering Vaccine(s)/Date _____	Clinic Site or Health Department _____
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