KENT COUNTY
HEALTH DEPARTMENT

LELAND D. SPENCER, M.D., M.P.H., HEALTH OFFICER
125 S. Lynchburg Street, Chestertown, Maryland 21620 Phone: (410) 778-1350

Please **Print** information about client

____ _________ **D.O.B.** _____/______/______
Last Name, **First Name** **MI** Age **Month** **Day** **Year**

____ **P. O. Box**__________________________
Street Address

_________________________________ ________ ____________ Phone: _________________
City **State** **Zip**

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Other:_________________

Sex: ☐ Male ☐ Female

Payment Options:

☐ **Cash- amount** _______________ ☐ **Check - #** ______________

☐ **Medicare #** _________________________ ☐ **Medical Assistance #** ____________________
Railroad Medicare #____________________ **(Insurance Name**: ______________________)

Signature of person to receive vaccine or person authorized to make the request:

I acknowledge that I have received today or have received in the past, a copy of the notice of Privacy Practices with an effective date of April 14, 2003. I have read or have had explained to me the information in the vaccine information statement.

Client Signature: ____ Date:______________

Parent Signature: ____ Date: ______________

Vaccine	FLU Vax	Pneumo Vax		
Date				
Vaccine Lot & Expiration	Sanofi Exp:6/2010			
Site of Injection	R L IM 0.5 CC deltoid			
Signature of vaccinator				