Annual Influenza Vaccine Consent Form – FLU SHOT

I have read or had explained to me the information about influenza and influenza vaccine. I have had a chance to have questions answered to my satisfaction, and request the vaccine be administered to me or the person named below for whom I am legally authorized to make this request. I understand the health department is already authorized to use the information gained during treatment to request payment upon day of service or bill Medicaid, Medicare or Insurance Carrier for reimbursement for services. I also acknowledge that I have had an opportunity to receive/read a copy of the "Joint Notice of Privacy Practices" dated 09/23/13 as well as the most current Vaccine Information Statement (VIS) from the health department.

PLEASE PRINT NAME EXACTLY AS ON IDENTIFICATION

NAME (Last)	(First)	(M.I.)
ADDRESS	CITY	

STATE	ZIP	PHONE #	BIRTHDATE	AGE

SIGNATURE	DATE

Illinois State Employee: Yes / No (circle)

**********For Clinic Use Only********

Date:_____ **Clinic Location:_____**

Do any of the following apply to person being vaccinated?

- ☐ I am feeling well
- ☐ Child 8 years or younger who has NEVER received a flu vaccine before
- ☐ Allergy to eggs or any other vaccine component
- ☐ Severe allergic reaction after an influenza vaccine
- ☐ History of Guillian-Barre' Syndrome

Vaccine Manufacturer: _____ **Lot #: _____ VIS 8/7/15**

Site:
Deltoid R or L

RN / Student Nurse:_____

PAYMENT:
- ☐ Cash
- ☐ Check # _____
- ☐ Credit
- ☐ Insurance _____
- ☐ Medicaid # _____
- ☐ Medicare # _____