

Coles County Health Department

Inactivated Influenza Vaccine Administration Record

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 or Medicare Part B **only** for reimbursement for services. I also acknowledge that I have had an opportunity to receive a copy of the "Joint Notice of Privacy Practices" dated 4/14/2003 as well as the most current Vaccine Information Statement (VIS) from the health department.

PLEASE PRINT

Last Name:	First Name:	Middle Initial:
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Street Address:	City:
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State:	Zip Code:	Phone #:	Birthdate:	Age:
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Do any of the following apply to person being vaccinated? Please check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> I am feeling well | <input type="checkbox"/> Allergy to eggs or any other vaccine component |
| <input type="checkbox"/> Child 8 years or younger who has never received a flu vaccine before | <input type="checkbox"/> Severe reaction after an influenza vaccine |
| | <input type="checkbox"/> History of Guillain-Barre' Syndrome |

Signature:	Date:
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Illinois State Employee **only** (last 4 digits of SS#): _____

For Clinic Use Only

Date: _____ Clinic Location: _____

Vaccine Manufacturer: Fluzone (Sanofi Pasteur) Fluvirin (Novartis) Flumist (MedImmune)	Lot #: _____ VIS 07/26/11 Lot#: _____ VIS 07/26/11 Lot#: _____ VIS 07/26/11 RN/LPN/Student Nurse: _____
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Site:
 Deltoid R or L
 Vastus Lateralis R or L

- Paid w/ Cash/Check #** _____
- Bill only Medicare Part B# (NO Supplemental Insurance)** _____
- Paid w/Visa / MC / Discover**
- Bill Medicaid (Public aid)#** _____
- Bill Railroad (Palmetto)#** _____