

Coles County Health Department

Live, Intranasal 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: |
|------------|-------------|-----------------|

| | |
|-----------------|-------|
| Street Address: | City: |
|-----------------|-------|

| | | | | |
|--------|-----------|----------|------------|------|
| State: | Zip Code: | Phone #: | Birthdate: | Age: |
|--------|-----------|----------|------------|------|

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"/> Heart disease | <input type="checkbox"/> Weakened immune system |
| <input type="checkbox"/> Child 8 years or younger who has never received a flu vaccine before | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Seizures disorder |
| <input type="checkbox"/> Allergy to eggs or any other vaccine component | <input type="checkbox"/> Asthma | <input type="checkbox"/> Long-term aspirin treatment |
| <input type="checkbox"/> Received vaccines in the past 4 weeks | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> History of Guilliaian-Barre' Syndrome |
| <input type="checkbox"/> Pregnant? | <input type="checkbox"/> Diabetes Metabolic disease | <input type="checkbox"/> Severe reaction after a dose of influenza |
| | <input type="checkbox"/> Anemia, other blood disorders | |
| | <input type="checkbox"/> Cerebral palsy | |

| | |
|------------|-------|
| Signature: | Date: |
|------------|-------|

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

For Clinic Use Only

Date: _____ **Clinic Location:** _____

| | | |
|---|--------------|--------------|
| Vaccine Manufacturer: Fluzone (Sanofi Pasteur) | Lot #: _____ | VIS 07/26/11 |
| Fluvirin (Novartis) | Lot#: _____ | VIS 07/26/11 |
| Flumist (MedImmune) | Lot#: _____ | VIS 07/26/11 |

Site:
 Intranasal R & L nostril **RN/LPN/Student Nurse:** _____

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