

Vaccine Administration Record

Client Name: _____

Birthdate: _____

Vaccine	Route ¹	Site ²	Type of Vaccine	Date given (mo/da/yr)	Vaccine Manf.	Vaccine Lot Number	VIS Materials Publication Date	Initials of Vaccinator
Influenza								
Typhoid								
Yellow Fever								
Zoster (Shingles)								
Other:								
Other:								

¹ Route Code: IM=intramuscular, SC=subcutaneous, IN=intranasal, PO=oral

² Site Code: LA=LT ARM, RA=RT ARM, LL=LT LEG, RL=RT LEG

Authorization for Treatment / Release of Information

I give consent to allow the Health Department staff to enroll me or the person named above in the program requested. I understand the nature and consequences of any procedures to be performed will be explained to me. I have been given a copy and have read or have had explained to me, the information contained on the appropriate Vaccine Information Statement (VIS) about the disease(s) and vaccine(s) which are to be administered today. I also give permission to release and/or obtain a vaccine record for myself or the person named above, to/from medical providers and/or school officials. I understand the Coles County Health Department is authorized to use the information gained in providing services to bill me, or other sources of payment, such as government programs in which I am enrolled.

Signature of person to receive vaccine or person authorized to make request.

1. Signature Date

2. Signature Date

3. Signature Date

4. Signature Date

5. Signature Date

6. Signature Date

7. Signature Date

8. Signature Date

9. Signature Date

10. Signature Date