CLAY COUNTY HEALTH DEPARTMENT
Influenza Vaccine Administration Record

Information about person to receive vaccine (Please Print in Ink and fill out completely)

Last Name: _____ First Name: _____ Middle Initial _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female Phone #: _____

Address:_____ City:_____ Zip:_____

(Please Check)

1. Have you or your child been sick or been running a fever in the past 24 hours? ☐ Yes ☐ No
2. Have you or your child ever had any severe reactions after receiving any vaccinations or medications? ☐ Yes ☐ No

   If Yes, please explain: _____

I have been given an opportunity to read the Notice of Privacy Practices for the Clay County Health Department. I have been given an opportunity to ask questions and believe I understand the benefits and risks of the influenza vaccine as stated on the "Vaccine Information Sheet". I understand the vaccine should not be taken if someone has had a severe reaction to a previous influenza vaccine, or if they have had Guillain-Barre Syndrome.

I request the vaccine be given to myself or my child named above, for whom I am authorized to give consent. I further permit payment directly to Clay County Health Department for services rendered and consent to have the immunization data entered into the State of Illinois Electronic Medical Record system called I-Care.

Signature: _____ Date: _____

Parent/Guardian Signature or Client if over 18

For Clinic/Office Use Only:

Insurance: (Aetna /BCBS / Cigna / Healthlink / Health Alliance / Humana / TriCare / Trustmark / UHC)

Insurance ID# _____ Insurance GROUP#: _____

Medicare Part B# _____ Medicaid (RIN) #: _____

Payment: Cash/Check#_____ or Credit Card VFC: ____ PVT: ____ 317: ____

Injection Date: _____ Vaccine: ☐ Fluzone HD ☐ Flulaval Lot #_____

Expiration Date: _____ Site: ☐ Right ☐ Left ☐ Deltoid ☐ Thigh

Nurse Signature: _____