

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: _____