Coles County Health Department
Child (6 months – 18years)
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. I understand the benefits and risks of influenza vaccine and request the vaccine be administered to me or the person named below for whom I am legally authorized to make this request.

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.

□ I am feeling well.
□ Pregnant?
□ Chronic medical condition?
□ Allergy to eggs or any other vaccine component?
□ Child 8 years or younger who has **never** received flu vaccine before?

I do hereby consent to allow the health department and its designated employees to enroll and provide services through the programs offered by the department. I understand the nature and consequences of any procedures to be performed will be explained to me. I understand the health department is already authorized to use the information gained during treatment to bill me, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify 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 from the health department

Signature:	Date:

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For Clinic Use Only

Date:_____ **Clinic Location:**_____

Vaccine Manufacturer: **Fluzone/Fluvirin** **Lot #:**_____
VIS 7/16/07

Site: **RN/LPN/Student Nurse:**_____

□ Deltoid R or L
□ Vastus Lateralis R or L

□ **Medicare #** _____
□ **Medicaid #** _____
□ **Paid Cash**
□ **VFC**

□ **Knows he/she needs flu #2 in 1 month.**
□ **Does not need additional doses this flu season.**

10/07