Coles County Health Department

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, 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, Medicare or Insurance Carrier 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 09/23/13 as well as the most current Vaccine Information Statement (VIS) from the health department.

PLEASE PRINT NAME EXACTLY AS ON IDENTIFICATION

Last Name:		First Name:		M.I.:
Street Address:		City:		
State: IL	Zip Code:	Phone #:	Birthdate:	Age:

Illinois State Employee: **Yes / No** (circle)

The provision of a flu shot is a gratuitous one being made available to you by your employer. You are not required to participate. If you choose to participate, please provide us with your birthdate. Giving this information is voluntary and is not mandated by any statute. The birthdate, along with other information on this form, will be used solely to facilitate prompt payment to the health care provider. Thereafter, information will become part of your healthcare records and will be kept confidential as required by HIPAA and all other federal statutes and regulations. The information will not be divulged without your consent or used for any purpose other than facilitating payment.

"How did you hear about us?" (circle all that apply) **radio tv newspaper website or facebook other:** _____

Signature:	Date:

********For Clinic Use Only********

Date:_____ **Clinic Location:**_____

Do any of the following apply to person being vaccinated?

- ☐ I am feeling well
- ☐ Child 8 years or younger who has **NEVER** received a flu vaccine before
- ☐ Allergy to eggs or any other vaccine component
- ☐ Severe reaction after an influenza vaccine
- ☐ History of Guillain-Barre' Syndrome

Vaccine Manufacturer: _____ **Lot #:** _____ **VIS** _____

Site:
Deltoid R or L
Vastus Lateralis R or L

RN / Student Nurse:_____

PAYMENT SOURCE: (circle one)
Cash / Credit / CK #_____
BCBS / Coventry / Health Alliance
Medicaid (Public aid)#_____
MEDICARE# _____