INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)

MUST BE *LEGAL* NAME **Last** **First** **Middle**		**Birth date**	**Sex**	**Age**
Address **City** **State** **Zip**		**Last 4 digits of your Social Security Number:**		
Phone #	**Physician Name:**	**Are you an Active or Retired State Employee: (flu only)** **Yes or No** **If yes-Who is/was employer: _____**		
RACE: ***(circle all that apply)*** **White; American Indian/Alaska Native; Asian; Black/African American; Native Hawaiian; OR Other**				
ETHNICITY: ***(circle all that apply)*** **Hispanic; Non-Hispanic; Asian; OR Mixed Race**				

Yes	No	
☐	☐	1. Is the client sick today?
☐	☐	2. Is the client allergic to eggs, baker's yeast, neomycin, sorbitol, latex or any vaccines?
☐	☐	3. Has the client had a serious reaction to any vaccine in the past?
☐	☐	4. Does the client have uncontrolled epilepsy or a history of seizures or other neurological problems?
☐	☐	5. Does the client have cancer, leukemia, HIV or any other immune system problem; in the last 3 months taken prednisone, other steroids, anticancer drugs, treatment for rheumatoid arthritis, Crohn's or had radiation treatment?
☐	☐	6. Has the client received a transfusion of blood, plasma or a medicine called immune globulin or antiviral drug in the past year?
☐	☐	7. Is the client pregnant or at risk for becoming pregnant within the next three months?

"I have read or have had explained to me by the nurse the VIS about the vaccine and all components that will be administered. I understand the potential contraindications to receiving the vaccine. My questions have been answered and I understand the risks and benefits of the vaccine and all the various vaccine components. I give my consent for the vaccine and all the various components to be administered to me or to the person named for whom I am authorized to make this request."

I request that Livingston County Health Department (LCHD) bill my insurance/Medicare/Medicaid policy for services rendered and authorize the payment of benefits be made on my behalf to LCHD for those services. I understand that I am responsible for payment for any deductible, co-pays, or any non-covered service furnished. In the event of non-coverage, financial arrangements can be made with LCHD.

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

X_____ Date_____
(Patient/Parent/Legal Guardian Adult Accompanying Child)

X_____ Date of Birth_____
PRINT NAME LEGIBLY RELATIONSHIP TO PATIENT Responsible Parent or Guardians

Cash$_____ Check$ and #_____ No Charge_____

Credit Card Vendor & Amt_____ Medicaid Number_____

Bill to Insurance – copy of insurance attached (need subscriber Date of Birth if not patient) _____

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Livingston County Public Health Department

310 E Torrance Avenue, Pontiac, IL 61764

Patient Name _____ Birthdate _____

Vaccine Administration Record for

Children and Teens

Date Vaccine & Info Sheet (VISs) given _____

VFC or Private Pay vaccine given (circle one)

Clinic Site _____

Before administering any vaccines, give copies of all pertinent Vaccine Information Statements (VISs) to the child's parent or legal representativeand and make sure he/she understands the risks and benefits of the vaccine (s).

If client refuses vaccine, make note next to the vaccine.

Vaccine	Type of Vaccine	Site	Vaccine Lot#	Vaccine Exp Date	Date on VIS	Vaccinator
Diphtheria, Tetanus, Pertusis	Daptacel (Sanofi) Infanrix (GSK) Tripedia (Sanofi)					
DTaP-IPV/HIB	Pentacel(Sanofi)					
DTaP-HepB-IPV	Pediarix (GSK)					
DTaP-IPV	Kinrix (GSK) Quadracel (Sanofi)					
Haemophilus influenza	ActHIB (Sanofi) Hiberix (GSK) PedvaxHIB (Merck)					
Hepatitis A	Havrix (GSK) Vaqta (Merck)					
Hepatitis B	Engerix-B (GSK) Recombivax HB (Merck)					
Hep A - Hep B	Twinrix (GSK)					
Human papillomavirus	Gardisil 9 (Merck)					
Influenza	Fluarix (GSK) Fluzone-25mg (Sanofi)					
Meningococcal ACWY; CY	Menactra (Sanofi) Menveo (GSK)					
Meningococcal B	MenB (GSK)					
MMR	MMRII (Merck)					
MMRV	ProQuad (Merck)					
Pneumococcal	Pneumovax 23 (Merck) Prevnar 13 (Pfizer)					
Polio (IPV)	Ipol (Sanofi)					
Rotavirus	Rotarix (GSK) Rota Teq (Merck)					
Td	Decavac, Tenivac (Sanofi) Generic (MA Lab)					
Tdap	Adacel (Sanofi) Boostrix (GSK)					
Varicella	Varivax (Merck)					
Other						

Entered into ICARE by _____

5/28/2019