# INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)

| MUST BE *LEGAL* NAME<br>Last Name First Name Middle Name | | | 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)<br>Yes or No<br>If yes-Who is/was employer: _____ | | |
| RACE: *(circle all that apply)* White; American Indian/Alaska Native; Asian; Black/African American; Native Hawaiian; OR Other<br>ETHNICITY: *(circle all that apply)* Hispanic; Non-Hispanic; Asian; OR Mixed Race | | | | | |

| Yes | No | |
|---|---|---|
| ☐ | ☐ | 1. Have you ever had a life threatening reaction to a flu shot? |
| ☐ | ☐ | 2. Have you ever had Guillain-Barre Syndrome? |
| ☐ | ☐ | 3. Have you ever had a severe allergy to eggs? |
| ☐ | ☐ | 4. Are you currently ill with a fever? |

**"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 or Check**_____ **No Charge**_____

**Credit Card Vendor & Amt**_____ **Medicaid Number**_____

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

*9/8/2021 Tan*

**Livingston County Public Health Department**
**310 E Torrance Avenue, Pontiac, IL 61764**

# Vaccine Administration Record

Patient Name_____

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine (s).

Birthdate_____

Clinic Site:

Date VIS & Vaccine Given: _____

Private Pay or 317

| Vaccine | Type of Vaccine | Site | Vaccine Lot# NDC# | Vaccine Exp Date | Date on VIS | Vaccinator |
|---|---|---|---|---|---|---|
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| Influenza | **Fluarix** Quadrivalent (GSK) 6 months and up | | | | | |
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| Influenza | **Flublok** Quadrivalent (Sanofi) 18 years and up/egg free; antibiotic free; preservative free | | | | | |
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| | | | | | | |
| Other | | | | | | |
| | | | | | | |
| Other | | | | | | |

Entered into ICARE by_____ 9/8/2021 Tan

Count entered by _____