

**Coles County Health Department  
Adult (19 & Up)**

**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.

<b>Last Name:</b>	<b>First Name:</b>	<b>Middle Initial:</b>
-------------------	--------------------	------------------------

<b>Street Address:</b>	<b>City:</b>
------------------------	--------------

<b>State:</b>	<b>Zip Code:</b>	<b>Phone #:</b>	<b>Birthdate:</b>	<b>Age:</b>
---------------	------------------	-----------------	-------------------	-------------

**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?
- Diabetes?

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.

<b>Signature:</b>	<b>Date:</b>
-------------------	--------------

---

**For Clinic Use Only**

**Date:** \_\_\_\_\_ **Clinic Location:** \_\_\_\_\_

**Vaccine Manufacturer:** Fluvirin/Fluzone/GSK **Lot #:** \_\_\_\_\_

**VIS:** 7/16/07

**RN/LPN/Student Nurse:** \_\_\_\_\_

**Injection Site:**

- Deltoid R or L
- Vastus Lateralis R or L

**Medicare #** \_\_\_\_\_

**Illinois State Employee**

**Medicaid #** \_\_\_\_\_

**Paid Cash**