

Coles County Health Department

Child (5 years to 18 years)

Live, Intranasal 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:
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Street Address:	City:
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State:	Zip Code:	Phone #:	Birthdate:	Age:
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Do any of the following apply to person being vaccinated? Please check all that apply.

- | | | |
|---|---|---|
| <input type="checkbox"/> I am feeling well. | <input type="checkbox"/> Heart disease? | <input type="checkbox"/> Long-term aspirin treatment? |
| <input type="checkbox"/> Pregnant? | <input type="checkbox"/> Lung disease? | <input type="checkbox"/> History of Guillan-Barre syndrome? |
| <input type="checkbox"/> Chronic medical condition? | <input type="checkbox"/> Asthma? | |
| <input type="checkbox"/> Allergy to eggs or any other vaccine component? | <input type="checkbox"/> Kidney disease? | |
| <input type="checkbox"/> Child 8 years or younger who has never received flu vaccine before? | <input type="checkbox"/> Diabetes / Metabolic Disease? | |
| | <input type="checkbox"/> Anemia, other blood disorders? | |
| | <input type="checkbox"/> Weakened immune system? | |

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: MedImmune **Lot #:** _____
VIS 7/16/07 (Interim)

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

Intranasal R & L nostril

Medicare # _____

Medicaid # _____

Paid Cash

VFC

8/07

Knows he/she needs flu #2 in 6-10 weeks.

Does not need additional doses this flu season.