LIVINGSTON COUNTY HEALTH DEPARTMENT – 310 E TORRANCE AVENUE, PONTIAC, IL 61764

MUST BE ***FULL LEGAL*** NAME Last Name First Name Middle Initial	Birth date	Sex	Age

Address City State Zip	

Phone #	If you are an Active or Retired State of Illinois Employee, please provide the following information: Last 4 digits of SS#_____ Employer Name: _____

Ethnicity: circle African American / Asian / Mexican American Indian / White Other: _____	Race: circle White / Black or African American / American Indian / Alaska Native / Asian / Native Hawaiian or Other Pacific Islander

VIS (Vaccine Information Sheet)
"I have read or have had explained to me by the nurse, 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."

ACKNOWLEGEMENT OF NOTICE OF PRIVACY PRACTICES SIGNATURE PAGE
By signing this form, you acknowledge that you have been given the opportunity to read our "Notice of Privacy Practices". This Notice describes in detail how we might use or disclose your protected health information. This Notice also discusses your rights and our duties with respect to your protected health information. You have the right to review the Notice before signing this acknowledgement.

BILLING
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.

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FOLLOWING TO BE COMPLETED BY LCHD STAFF

Vaccine Administration Record

Before administering any vaccines, give the patient or child's parent or legal representative, copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine (s). ***If client refuses vaccine, make note next to the vaccine.***

Date Vaccine Given & VIS form handed out _____

Date on VIS information form - 8/6/2021

VFC or CHIP or Private Pay (vaccine given-circle one)

Vaccine	Type of Vaccine	Site	Vaccine Lot#	Vaccine Exp Date	Vaccinator
Influenza	Fluarix – FluZone				
Other					

Method of Payment_____

9/2023

Screening Checklist for Contraindications to Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH ____/____/____
month day year

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain Barré syndrome?	☐	☐	☐
5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
6. Is the person to be vaccinated anxious about getting a shot today?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

RELATIONSHIP TO PATIENT _____

FORM REVIEWED BY VACCINATOR - see front side