Vaccine Request Form

1002 East Laurel Ave, Havana, IL 62644 ■ Phone: (309) 210-0110 ■ Fax: (309) 543-2063

Patient Information

Legal First & Last Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Street Address: _____ City: _____ ZIP: _____

Phone Number: _____ Email: _____

Name of Parent/Guardian (if applicable): _____

Is the patient Hispanic?
☐ No
☐ Yes
☐ Prefer not to answer

What race is the patient? (check all that apply)
☐ White ☐ Black or African American ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Other: _____ ☐ Prefer not to answer

1. Does the patient have any allergies to medications, foods, or latex? ☐ No ☐ Yes If yes, what? _____
2. Has the patient ever had a serious reaction to a vaccine in the past? ☐ No ☐ Yes
3. Does the patient have any long-term health problems? ☐ No ☐ Yes If yes, what? _____
4. In the past 3 months, has the patient taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; had radiation treatment; been on long-term aspirin therapy? ☐ No ☐ Yes
5. Has the person to be vaccinated ever felt dizzy or faint before or after a shot? ☐ No ☐ Yes
6. Name of patient's primary doctor or healthcare provider? _____

Acknowledgments & Consent

By signing below, I acknowledge, authorize, and consent to the following:

- I was provided with a copy of Mason County Health Department's *Notice of Privacy Practices*.
- I authorize the release of medical or other information to CMS, insurance carrier(s), or other necessary entities to determine benefits payable for services provided by MCHD. I understand insurance billing is a courtesy, and I remain financially responsible for payment. I authorize my insurance carrier(s) to make payment directly to MCHD.
- I authorize MCHD to administer treatment or provide necessary services to the patient named above. I certify that I am the patient or the parent/legal guardian of the patient. I consent to the use of the Athenahealth HER system to manage my health information. By providing contact information, I agree MCHD may contact me by automated call, text, or email regarding appointments, closures, or other relevant information. I understand I may revoke this consent in writing at any time.
- I have received a *Vaccine Information Statement (VIS)* for each vaccine requested and had the opportunity to ask questions. I understand the benefits and risks and request the vaccine(s) be given to the person named above.

_____ _____

Patient's or Authorized Person's Signature Date

OFFICIAL USE ONLY

	FLU		
Mfgr.	Fluzone		
Lot #			
Dosage			
Site/Route	/IM		
VIS Given	1/31/25		

Clinic Site: MCHD / Other: _____

Signature & Title of Vaccine Administrator: _____

Date: _____ Comments: _____