Mason County Public Health
Prevent. Promote. Protect.

Mason County Health Department

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

School Flu Shot Clinic

Mason County Health Department, in cooperation with Illini Central School District, will offer flu vaccinations to students at school on Thursday, October 1st, 2026.

If you would like your child to receive a flu shot, please complete the attached consent form, including copies of insurance cards, and return it to the school by September 22nd. A signed consent form and complete insurance information is required for each child being vaccinated. Children who do not have health insurance may also receive a flu vaccine at no cost under the VFC program.

Registered nurses from Mason County Health Department will come to each of the schools to administer the flu shots. This program helps protect students, families, and staff by reducing illness, absences, and the spread of influenza in our community. Children are among the most common sources of flu transmission because of their close contact with one another and limited ability to consistently follow infection prevention habits.

The CDC recommends vaccination by the end of October, before flu begins circulating widely. It takes about two weeks after vaccination for antibodies to develop. A Vaccine Information Statement (VIS) for the flu shot is available by scanning the QR code below.

What to Expect:

- Some arm soreness after the injection is normal. Your child should keep using the arm as usual – movement actual helps reduce soreness.
- For billing and documentation purposes, each student must be "scheduled" in our EHR. While we have tried to disable this, you may receive a notification that your child has an appointment at Mason County Health Department. Please disregard this message – your child will receive the vaccine at school as planned.
- Please have your child wear a short sleeve shirt or layers that are easy to remove on October 1st, as the injection will be given in the upper arm.

If you have any questions, call MCHD at (309) 210-0110.

Mason County Public Health
Prevent. Promote. Protect.

Flu 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 ☐ Other: _____
☐ Native Hawaiian or Other Pacific Islander ☐ 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 R / H		
	Fluzone		
Lot #			
Dosage	0.5 ml		
Site/Route	/IM		
VIS Given	1/31/25		

Clinic Site: MCHD / Other: _____

Signature & Title of Vaccine Administrator: _____

Date: _____ Comments: _____