Maple Street Clinic
109 E. Maple, Gillespie, IL 62033
217-839-1526 – Medical/Behavioral
217-839-1538 - FAX
217-839-4110 – Dental

Macoupin County Public Health Department

Morgan Street Clinic
1115 Morgan Street, Carlinville, IL 62626
217-854-3692 – Medical/Behavioral
217-930-2293 – FAX
217-854-6823 – Dental

Columbian Blvd. Dental Clinic ~ 125 W. Columbian Blvd. South ~ Litchfield, IL 62056 ~ 217-250-2360 (p) ~ 217-250-2365 (fax)
St. Francis Way Clinic ~ 805 St. Francis Way ~ Litchfield, IL 62056~ 217-250-2380 (p) ~ 217-250-2385 (fax)
Oakland Avenue Clinic ~ 205 Oakland Ave. ~ Carlinville, IL 62626 ~ 217-854-3233 (p) ~ 217-854-2116 (fax)

Influenza Vaccine Administration Record

Inactivated Injectable Influenza Vaccination

INFORMATION ABOUT PERSON TO RECEIVE VACCINE

Please Print:

Last Name:_____ First Name:_____ MI:_____

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Age: _____

Address: _____
(Street Address) (City) (State) (Zip)

County: _____ Phone Number: _____

Email Address: _____

Emergency Contact: _____ **Phone Number:** _____

RACE/ETHNICITY (mark ALL that apply):

☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ White ☐ Other

INSURANCE COMPANY NAME (please circle all that apply):

Medicare Medicaid Medicaid MCO Private Insurance: _____

Policy Information:

Name of Policy Holder: _____ Policy Holder's DOB: _____/_____/_____

Policy# or Medicare/Medicaid# Number: _____

Member/Group Number: _____ Effective Date: _____

Does the person receiving the vaccine:

Have an allergy to eggs or to a component of the vaccine?	☐ Yes	☐ No
Sick today?	☐ Yes	☐ No
Ever had a serious reaction to influenza vaccine in the past?	☐ Yes	☐ No
Ever had Guillain-Barre Syndrome?	☐ Yes	☐ No
Is the person receiving the vaccine today pregnant?	☐ Yes	☐ No

I have read or have had explained to me the information contained on the 2023 Vaccine Information Sheet about vaccine(s) that will be administered. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) checked be given to me or to the person named above for who I am authorized to make this request. If applicable, the above-named minor has my consent to receive services offered by the Macoupin County Public Health Department.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I have been given an opportunity to read the Notice of Privacy Practices for the Macoupin County Public Health Department and to have any questions answered before signing.

Signature of person to receive the vaccine or person authorized to make the request:

Printed Name: _____ **Relationship to patient:** _____

Signature: _____ Parent/Guardian DOB: _____ **Date:** _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

----------↓↓↓ FOR OFFICE USE ONLY ↓↓↓----------

DATE ADMINISTERED: _____

Influenza	High Dose Influenza
Exp. Date: _____	Exp. Date: _____
SITE ADMINISTERED:	**SITE ADMINISTERED:**
☐ LUE	☐ LUE
☐ LLE	☐ LLE
☐ RUE	☐ RUE
☐ RLE	☐ RLE

☐ VFC

☐ CHIP

☐ 317

☐ Employer Program

_____

☐ Private Insurance

☐ Self-Pay/Out of Pocket

ADMINISTERED BY:

☐ Christy Blank, RN _____ ☐ Bailey Jarman, RN _____

☐ Jennifer Swank, RN _____ ☐ Samantha Thomas, FNP-BC _____

☐ Gary Ross, RN _____ ☐ Elizabeth Tucker, CMA _____

☐ Julie Pfeiffer, RMA _____ ☐ Kendra Owens, RMA _____

COMMENTS: _____

_____

_____

_____