Maple Street Clinic
109 E. Maple, Gillespie, IL 62033
2 17-839-1526 – Medical/Behavioral
217-839-1538 - FAX

217-839-4110 – Dental

Morgan Street Clinic
1115 Morgan St., Carlinville, IL 62626

Medical/Behavioral - 217-854-3692
FAX – 217-930-2293
Dental - 217-854-6823

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 ~ 217-854-3223 (p) ~ 217-854-3225 (fax)

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 MCO: ______________________ Private Insurance: ______________________________

Policy Information:

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

Policy# or Medicare/Medicaid# Number: ____

Member/Group Number: ______________________________ Effective Date: ____________________

I have read or have had explained to me the information contained on the 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 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:**___________________________

PARENT/GUARDIAN DOB (IF APPLICABLE): _____________________________

SIGNATURE:________________________________ **DATE:**________________

Updated 9/18/2024

PATIENT NAME:_______________________________ **DATE OF BIRTH:**________________________

↓↓↓ FOR OFFICE USE ONLY ↓↓↓

VACCINE ADMINISTRATION RECORD

☐ VFC ☐ 317 ☐ PRIVATE PAY

	VIS Date	Manufacturer	Lot #	Exp. Date	Dose #	Admin Site
COMIRNATY 12+	VIS 10-19-23	PFIZER				
PFIZER-BIONTECH COVID-19 5-11Y	EUA 8-22-24	PFIZER				
PFIZER-BIONTECH COVID-19 6M-4Y	EUA 8-22-24	PFIZER				
DTAP/INFANRIX	VIS 08-06-21	GSK				
DTAP-IPV/KINRIX	VIS 07-24-23	GSK				
DTAP-IPV-HEP B/PEDIARIX	VIS 07-24-23	GSK				
HEP A/HAVRIX	VIS 10-15-21	GSK				
HEP B/ENGERIX	VIS 05-12-23	GSK				
HIB/HIBERIX	VIS 08-06-21	GSK				
HPV/GARDASIL 9	VIS 08-06-21	MERCK				
INFLUENZA 6M+	VIS 08-06-21	GSK				
INFLUENZA HIGH DOSE	VIS 08-06-21	SEQIRUS				
IPV/IPOL	VIS 08-06-21	SANOFI				
MCV4/MENVEO	VIS 08-06-21	GSK				
MEN B/BEXSERO	VIS 08-06-21	GSK				
MMR II	VIS 08-06-21	MERCK				
MMR/PRIORIX	VIS 08-06-21	GSK				
MMRV/PROQUAD	VIS 08-06-21	MERCK				
PCV13/PCV20/PREVNAR	VIS 05-12-23	PFIZER				
ROTAVIRUS/ROTARIX	VIS 10-15-21	GSK				
RSV/BEYFORTUS	VIS 10-19-23	SANOFI				
TDAP/BOOSTRIX	VIS 08-06-21	GSK				
VARICELLA/VARIVAX	VIS 08-06-21	MERCK				

DATE ADMINISTERED:____

ADMINISTERED BY:____