☐ VFC ☐ 317 ☐ PRIVATE PAY

VACCINE IMMUNIZATION RECORD – 1 OF 2

Updated 09/05/2025

Maple Street Clinic
109 E. Maple, Gillespie, IL 62033
217-839-1526 ~ Medical/Behavioral
217-839-1538 ~ Medical/Behavioral (fax)
217-839-4110 ~ Dental
217-839-4105 ~ Dental (fax)

Macoupin County
Public Health Department

Morgan Street Clinic
1115 Morgan St., Carlinville, IL 62626
Medical ~ 217-854-3692
Dental ~ 217-854-6823
Medical & Dental (fax) ~ 217-930-2293

Administrative Office ~ 205 Oakland Ave ~ Carlinville, IL ~ 217-854-3223 (p) ~ 217-854-3225 (fax)
St. Francis Way Clinic ~ 805 St. Francis Way ~ Litchfield, IL 62056 ~ 217-250-2380 (p) ~ 217-250-2385 (fax)
Columbian Blvd. Dental Clinic ~ 125 W. Columbian Blvd. South ~ Litchfield, IL 62056 ~ 217-250-2360 (p) ~ 217-250-2365 (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:**_____

Screening Checklist for Contraindications to Injectable Influenza Vaccine (Inactivated "IIV," Cell Culture "ccIIV," or Recombinant "RIV")

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 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 _____

FORM REVIEWED BY _____ DATE _____