Form of Payment:

INFLUENZA VACCINE ADMINISTRATION RECORD FOR CHILD RECIPIENT

I have read or have had explained to me the informational sheet about the influenza and the influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request. I also hereby acknowledge that I received a copy of the "Notice of Privacy Practices" from the Logan County Dept. of Public Health revised 9/23/2013.

***PLEASE PRINT**

Name: ____________ Last ____________ First ______ M.I.			**Sex:** (circle one) **Male** **Female**
Date of Birth: ______/______/______	**Age:**	**Phone Number:** ( ) -	**Doctor's Name:**
Address: ____________ Street ______ City ______ County ______ State ______ Zip			
Is the recipient pregnant? ☐ Yes ☐ No		**Does the recipient have an allergy to eggs?** ☐ Yes ☐ No	
Signature of person to receive vaccine or authorized to make the request: **X** ______________________________ (Recipient *or* Parent/Legal Guardian)			**Date:** ______/______/______

(Questions only for children **6 months** through **8 years** of age)

YES	NO	
		Has the recipient ever received seasonal flu vaccine?
		Was last year the recipient's first to receive the seasonal flu vaccine?
		Did the child receive 2 doses of seasonal influenza vaccine last year?

Please Note: In the event of non-payment by Medicare or Medicaid, client served or guardian will be held responsible for the payment and will receive such statement/invoice.

Initials:____________

Medicaid Recipients/AllKids, please include:

Recipient #: ______________________________

For Clinic Use Only

Clinic or Office Address: LCDPH ☐ HOPE ☐ OTHER ____________________

Date Vaccine Administered: _____/_____/______

Vaccine Manufacturer:	**Sanofi** 6-35 Mos.	**Medimune Flu Mist** Quadrivalent	**GSK Fluarix** Quadrivalent 3 & up	**Sanofi** Non-VFC 6 Mos & Up
Vaccine Lot Number:	**UH692CA**	**BH2124**	**F5575**	**UH906AA**

Site of Injection: R Arm ☐ L Arm ☐ R Leg ☐ L Leg ☐

Signature and Title of Vaccine Administrator: ______________________________

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

PATIENT ELIGIBILITY SCREENING RECORD

VACCINES FOR CHILDREN (VFC) *PLUS* PROGRAM

Date:________________________

Patient:____

Last Name First Name MI

Date of Birth:___________________________ Age:_________________

Provider: **Logan County Department of Public Health, 109 Third Street, Lincoln, IL 62656-0508**

A record must be kept in the health care provider office that reflects the status of all children 18 years of age or younger, who receive immunization through the VFC *Plus* Program. The record may be completed by the parent, guardian or the individual of record, or by the health care provider. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

The parent or guardian has stated that this child qualifies for vaccination through the federal Vaccines For Children (VFC) program because he or she (check only one box):

A. Is enrolled in Medicaid _____

B. Does not have health insurance _____

C. Is American Indian or Alaskan Native _____

OR this child does not qualify for vaccination through the Vaccines For Children (VFC) program (unless the provider is a Federally Qualified Health Center or Rural Health Clinic); however, this child may be provided vaccine through the Illinois Vaccines for Children (VFC) *Plus* Program because he or she:

D. Has health insurance that does not pay for vaccines (underinsured). _____

The above eligibility status information was provided by me to my child's health care provider.

____ ____________________

Signature of Parent or Legal Guardian Date

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