Effingham County Health Department
901 W Virginia Ave
Effingham, IL 62401
Phone: 217-342-9237 Fax: 217-342-9324

Influenza Vaccine Consent Form

First Name: _____ Last Name: _____ Date: _____

DOB: _____ Age: _____ Phone Number: _____

Address: _____ City: _____ Zip Code: _____

Consent

I have been offered the current influenza vaccine information sheet (VIS). I have been provided education and given an opportunity to ask questions about the disease and vaccination. I understand the risks and benefits of the vaccination. I understand that the vaccination I am to receive is a single shot for adults and for children who have received a flu vaccine in previous years. Children, age 7 years and younger, receiving their first dose of influenza vaccine require a second dose in that same season.

I understand that it will not be fully effective for approximately two weeks However, with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I understand that one should not receive the vaccine if they have a severe allergy to eggs, have had a severe reaction to a previous influenza vaccine, or if they have had Guillain-Barre Syndrome. I hereby request the influenza vaccine for the 2024-2025 flu season be given to myself or the person for whom I am authorized to give consent.

I authorize the Effingham County Health Department to bill my Insurance for the vaccine and administration.

I also consent to have my immunization data entered into the State of Illinois Electronic medical Record system called I-Care.

Patient or Guardian's Signature: _____ Date: _____

Witnessed/Administered By: _____ Date: _____

CLINIC/OFFICE USE ONLY

Vaccine: Lot #: _____ Expiration Date: 06/30/2025

Site: Right Left Deltoid Thigh

Eligibility: 317 Private VFC

Nurse: ASintim-Aboagye JBoone KEnloe KHowell KHughes DLueken BMiller LOhnesorge LFrost

EZ Encounter_____ EZ Charted_____ IC Check_____ Scanned_____

Updated 9/13/24