



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

Influenza Vaccine Consent Form

Name: _____ DOB: _____

Address: _____

Phone Number: _____ Date: _____

Consent

I have been offered or given the current influenza vaccine information sheet (VIS). I have been provided 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 the past.

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 2022-2023 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 Medicaid, Medicare, or my Private Insurance for the administration of this vaccine.

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

Patient/Guardian's Signature: _____ Date: _____

Witnessed/Administered By: _____ Date: _____

CLINIC/OFFICE USE ONLY

Vaccine: Lot #: _____ Expiration Date: 06/30/2024

Site: Right Left Deltoid Thigh

Eligibility: 317 Private VFC

Nurse: SDuplayee KEnloe KHowell KHughes DLueken LOhnesorge