Franklin- Williamson Bi-County Health Department Vaccine Administration Record and Informed Consent

First Name:_____**Last Name:**_____
Address_____**City:**_____
Date of Birth:_____**Age:**_____**Phone:**_____
Physician:_____

Please Circle:

Race: ****American Indian/Alaskan Native****Asian****White****
****Black/African American****Native Hawaiian/Other Pacific Islander****Other

Ethnicity:Hispanic/Latino****Not Hispanic/Latino****Other

Sex: Female Male Other_____

1.Is the person to be vaccinated sick or injured today? If Yes, new fever, a cough, diarrhea, or vomiting?	YES NO
Does the person have an open wound, puncture, or tissue test that prompted a tetanus shot?	YES NO
2. Does the person have allergies to medications, food components, vaccine components, or latex?	YES NO
3. Does the person have a chronic health condition or long-term health problem?	YES NO
Are you on blood thinner medication?	YES NO
4. Has the person ever had a seizure disorder for which they are on seizure medications, a brain disorder, Guillain-Barre Syndrome, or other nervous system problem?	YES NO
5. Has the person ever had a reaction, fainted, or felt dizzy after receiving a vaccine, have a history of thrombocytopenia, or has any physician or other healthcare professional ever cautioned or warned about receiving certain vaccines or receiving vaccines outside of a physician's office or hospital?	YES NO
6. Is the person currently pregnant or considering becoming pregnant in the next month?	YES NO
7. Does the person have a weakened immune system or been told by a physician that they are immunosuppressed?	YES NO
8. Has the person received any vaccinations or skin tests in the past four weeks?	YES NO
9. Is the person currently on medications that weaken the immune system?	YES NO
10. Has the person received a transfusion of blood or blood products or been given immune (gamma) globulin in the past year?	YES NO

Please read the section below carefully and sign and date acknowledging that you understand and agree.

I consent to vaccine administration by Franklin-Williamson Bi-County Health Department, its employees (registered nurses or licensed practical nurses). I received the Vaccine Information Statement or Emergency Use Authorization for vaccine(s). The risks and benefits were explained to me. My questions were answered to my satisfaction.
Initials:_____

Disclosure of Records: I acknowledge and consent to the reporting of this vaccine administration to the Illinois Comprehensive Automated Immunization Registry Exchange (ICARE). I can Opt-Out of the disclosure of my information to the state registry by completing an approved form. **Initials:**_____

Patient: ☐ **Legally Authorized Representative:** ☐

Signature:_____

If not patient: Relationship to Patient:_____ **Name:**_____

This page to be completed by health care provider ONLY: ☐ VFC ☐ PP ☐ Bridge ☐ 317

Vaccine	Lot#	Site
		R L Deltoid upper arm VL IM SQ
		R L Deltoid upper arm VL IM SQ
		R L Deltoid upper arm VL IM SQ
		R L Deltoid upper arm VL IM SQ
		R L Deltoid upper arm VL IM SQ
		R L Deltoid upper arm VL IM SQ
		R L Deltoid upper arm VL IM SQ

Circle below VIS/EUA received:

COVID 12+	Spikevax COVID 19 Moderna	
COVID 12+	Comirnaty COVID 19 BioNTech/Pfizer	
COVID 6mo-11Y	Moderna COVID 19	EUA 09/11/23
COVID 6mo-11Y	Pfizer-BioNTech	EUA 09/11/23
COVID	Novavax	EUA 10/03/23
Dtap	Infarix GSK	8/6/21
Hep A	Havrix GSK Twinrix GSK	10/15/21
Hep B	EngerixB Peds Engerix B Adult Twinrix	05/12/23
Hib	Hiberix GSK	08/06/21
HPV	Gardasil 9 Merck	08/06/21
IPV	IPOL Sanofi	08/06/21
Flu	Fluarix GSK Flublok Sanofi Flulzone HD Sanofi	08/06/21
Men ACWY	Menveo GSK	08/06/21
MenB	Bexsaro GSK	08/06/21
MMR	MMR II Merck	08/06/21
MMRV	Proquad Merck	08/06/21
Mulit	Pediarix GSK Pentacel Sanofi Vaxelis Sanofi Kinrix GSK	07/24/23
PCV	Vaxneuvance PCV 15 Merck Prevnar 20 CPV 20 Pfizer	05/21/23
PPSV 23	Pneumovax 23 Merck	10/30/19
RSV Vaccine	Abrysvo GSK	07/24/23
RSV Antibody	Beyfortus	09/25/23
Rota	Rotateq Merck	10/15/21
Monkeypox	Mpox Jynneos	11/14/22
Td	TD VAX Sanofi	08/06/21
Tdap	Boostrix GSK	08/06/21
Varicella	Varivax Merck	08/06/21
Zoster	Shingrix GSK	02/04/22

Weight of infant if receiving Beyfortus_____

Order from OB documenting EDC_____Scanned into Athena Yes No

☐ Scanned from Vaxcare ☐ Added to ICARE

Date:_____

Nurse Signature:_____

Benton Marion Homebound Off- Site_____