

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

Date: _____
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?
Does the person have an open wound, puncture, or tissue test that prompted a tetanus shot? | YES NO
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?
Are you on blood thinner medication? | YES NO
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 problems? | 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

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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

COVID 12+	Spikevax COVID 19 Moderna	10/19/2023
COVID 12+	Comirnaty COVID 19 BioNTech/Pfizer	10/19/2023
COVID 6mo-11Y	Moderna COVID 19	EUA 09/11/23
COVID 6mo-11Y	Pfizer-BioNTech	EUA 09/11/23
Dtap	Infanrix GSK	8/6/21
Hep A	Havrix GSK Twinrix GSK	10/15/21
Hep B	Engerix B 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 Fluzone HD Sanofi	08/06/21
Men ACWY	Menveo GSK	08/06/21
Men B	Bexsaro GSK	08/06/21
MMR	MMR II Merck	08/06/21
MMRV	Proquad Merck	08/06/21
Multi	Pediarix GSK Pentacel Sanofi Vaxelis Sanofi Kinrix GSK	07/24/23
PCV	Vaxneuvance PCV 15 Merck Prevnar 20 PCV 20 Pfizer	05/21/23
PPSV 23	Pneumovax 23 Merck	10/30/19
RSV	Abrysvo GSK	07/24/2023
Rota	Rotateq Merck	10/15/21
Monkeypox	Mpox Jynneos	11/14/2022
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

Scanned from Vaxcare

Added to ICARE

Date: _____

Nurse Signature: _____

Benton Marion Homebound Off- Site _____