

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? | 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 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 ☐ VFA ☐ PP

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

Beyfortus (10/1-3/31, < 8mo 0days): Age of infant: _____ Weight of infant: _____

Abrysvo (9/1-1/31, 32 weeks 0 days through 36 weeks 6 days): Gestational Age: _____ Rx Yes

Notes: _____

Circle below which VIS given. VIS was given the same day as immunization administered.

COVID 12+	Spikevax COVID 19 Moderna Comirnaty COVID 19	01/31/25
COVID 6mo-11Y	BioNTech/Pfizer Moderns COVID 19 Pfizer-BioNTech	01/31/25
Dtap	Infanrix GSK	08/6/21
Hep A	Havrix GSK Twinrix GSK	01/31/25
Hep B	Engerix B Peds Engerix B Adult Twinrix	01/31/25
Hib	Hiberix GSK	08/06/21
HPV	Gardasil 9 Merck	08/06/21
IPV	IPOL Sanofi	01/31/25
Flu	Fluarix GSK Flublok Sanofi Fluzone HD Sanofi	01/31/25
Men ACWY	Menveo GSK	01/31/25
Men B	Bexsaro GSK	01/31/25
MMR	MMR II Merck	01/31/25
MMRV	Proquad Merck	01/31/25
Multi	Pediarix GSK Pentacel Sanofi Vaxelis Sanofi Kinrix GSK	07/24/23
PCV	Vaxneuvance PCV 15 Merck Prevnar 20 PCV 20 Pfizer	05/12/23
PPSV 23	Pneumovax 23 Merck	10/30/19
RSV vaccine	Abrysvo GSK	01/31/25
RSV antibody RSV II	Beyfortus Sanofi AstaZeneca	09/25/23
Rotavirus	Rotateq Merck	10/15/21
Monkeypox	Mpox Jynneos	01/31/25
Td	TD VAX Sanofi	08/06/21
Tdap	Boostrix GSK	01/31/25
Varicella	Varivax Merck	01/31/25
Zoster	Shingrix GSK	02/04/22

☐ Scanned from Vaxcare

☐ Added to ICARE

Date: _____

Nurse Signature: _____

Benton Marion Homebound Off- Site _____