VACCINE ADMINISTRATION RECORD – 2022

Information about person TO RECEIVE vaccine: Please print AS IT APPEARS ON INSURANCE CARD

LAST NAME_____ FIRST NAME_____ MI_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

DATE OF BIRTH_____ AGE_____ M_____ F_____ PHONE #:_____

MARK PAYMENT SOURCE (CHECK ONE):

☐ MEDICARE* ☐ NON-TRADITIONAL MEDICARE* ☐ PUBLIC AID* ☐ PRIVATE INSURANCE*

☐ SELF PAY ☐ STATE EMPLOYEE+

INSURANCE COMPANY: _____ ID #: _____ GROUP #: _____

POLICY HOLDER NAME: _____ POLICY HOLDER DATE OF BIRTH: _____

POLICY HOLDER ADDRESS: _____

*MUST have copy of card & read and sign the statement at the bottom of this form +MUST have social security number

Put an "x" in the box below to indicate that you have the HIPAA information.

☐ **HIPAA** – I understand a *Notice of Privacy Practices* is available at my request. Under the Healthcare Insurance Portability and Accountability Act, I authorize to disclose my Immunization Record to my physician and/or school. I also authorize the following person(s) to have access to my records: *(It's OK if you don't write anyone's name)* _____

SCREENING CHECKLIST FOR CONTRAINDICATIONS TO VACCINES

The following questions will help us to determine which vaccines the client may be given today. If you answer "yes" to any question, it does not necessarily mean the client should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask clinic staff to explain.	**Yes**	**No**	**Don't Know**
1. Is the client sick today, or has the client had a fever over 100 degrees in the past 24 hours?	☐	☐	☐
2. Do you have allergies to medications, food (including eggs), a vaccine component, or latex? If yes, list here:	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you (or anyone who lives with you) have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
5. In the past 3 months, have you taken medications that weaken your immune system, (cortisone, prednisone, other steroids, or anticancer drugs) or have you had radiation treatments?	☐	☐	☐
6. Have you had a seizure or a brain or other nervous system problem, including Guillain-Barre syndrome?	☐	☐	☐
7. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug, including influenza antiviral medications?	☐	☐	☐
8. For women: Are you pregnant or breastfeeding, or is there a chance of you being pregnant during the next month?	☐	☐	☐
9. Have you received any vaccines in the past 4 weeks? Or a TB skin test in the past 3 days?	☐	☐	☐
10. Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (such as for bone marrow transplant)?	☐	☐	☐
11. Do you have any of the following health problems? Please circle: Lung disease (including asthma) Immunocompromised Kidney disease Metabolic disease (such as diabetes) Neurologic or neuromuscular disorder Liver disease Heart disease (except isolated high blood pressure Blood disorder None			
12. (If adult) Have you ever had a pneumonia vaccine before? Yes No Don't Know If yes, which type: How many: When:			

"I have completed this form to the best of my knowledge. I have been given, read and understand the possible side effects described in the Vaccine Information Statement (VIS) that could be caused by the vaccine(s). I give my consent for vaccines to be administered as indicated. I agree to pay CCHD for any services not covered or paid by my insurance, and I understand that CCHD may bill me for this amount."

Signature of person to receive vaccine or person authorized to make the request:

X_____ **Date:** _____

Nurse Reviewing Form:

X_____ **Date:** _____

CLIENT NAME: _____

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THIS SIDE FOR CCHD STAFF USE ONLY

Td ☐	**Tdap** ☐	**Hep A** ☐	**Hep B** ☐
(Tetanus, Diphtheria)	(Tetanus, Diphtheria, Pertussis)	(Hepatitis A Vaccine)	(Hepatitis B Vaccine)
VIS date:	**VIS date:**	**VIS date:**	**VIS date:**
Vaccine Administration Date:	**Vaccine Administration Date:**	**Vaccine Administration Date:**	**Vaccine Administration Date:**
Manufacturer:	**Manufacturer:**	**Manufacturer:**	**Manufacturer:**
Lot #:	**Lot #:**	**Lot #:**	**Lot #:**
Site of Injection: **Dose #**	**Site of Injection:** **Dose #**	**Site of Injection:** **Dose #**	**Site of Injection:** **Dose #**
IPV ☐	**DTap** ☐	**HPV: Gardasil or Cervarix** ☐	**PCV13** ☐
(Inactivated Polio Vaccine)	(Diphtheria, Tetanus, and Pertussis)	(Human Papillomavirus Vaccine)	(Pneumoccoccal conjugate Vaccine)
VIS date:	**VIS date:**	**VIS date:**	**VIS date:**
Vaccine Administration Date:	**Vaccine Administration Date:**	**Vaccine Administration Date:**	**Vaccine Administration Date:**
Manufacturer:	**Manufacturer:**	**Manufacturer:**	**Manufacturer:**
Lot #:	**Lot #:**	**Lot #:**	**Lot #:**
Site of Injection: **Dose #**	**Site of Injection:** **Dose #**	**Site of Injection:** **Dose #**	**Site of Injection:** **Dose #**
MCV4 ☐	**Varicella** ☐	**MMR** ☐	**Hib** ☐
(Meningococcal conjugate Vaccine)	(Chickenpox Vaccine)	(Measles, Mumps & Rubella Vaccine)	(Haemophilus Influenzae Type B)
VIS date:	**VIS date:**	**VIS date:**	**VIS date:**
Vaccine Administration Date:	**Vaccine Administration Date:**	**Vaccine Administration Date:**	**Vaccine Administration Date:**
Manufacturer:	**Manufacturer:**	**Manufacturer:**	**Manufacturer:**
Lot #:	**Lot #:**	**Lot #:**	**Lot #:**
Site of Injection: **Dose #**	**Site of Injection:** **Dose #**	**Site of Injection:** **Dose #**	**Site of Injection:** **Dose #**
Pentacel ☐	**Kinrix** ☐	**Rotorix - Rotateq** ☐	☐
(DTap/IPV/Hib combined Vaccine)	(DTaP/Polio Vaccine)	(Votavirus Vaccine)	
VIS date:	**VIS date:**	**VIS date:**	
Vaccine Administration Date:	**Vaccine Administration Date:**	**Vaccine Administration Date:**	
Manufacturer:	**Manufacturer:**	**Manufacturer:**	
Lot #:	**Lot #:**	**Lot #:**	
Site of Injection: **Dose #**	**Site of Injection:** **Dose #**	**Site of Injection:** **Dose #**	
Influenza **Injectable** ☐	**Pneumonia** ☐	☐	☐
VIS date:	**VIS date:**		
Vaccine Administration Date:	**Vaccine Administration Date:**		
Manufacturer:	**Manufacturer:**		
Lot #:	**Lot #:**		
Site of Injection: **Dose #**	**Site of Injection:** **Dose #**		

Vaccine Administration Signature:

X_____

Title: _____ **Date:** _____

Date Billed: _____ Date Reported on Tracking Spreadsheet: _____

Date Reported on Adult Vaccine Card or in I-CARE: _____

STATE OF ILLINOIS
CORNERSTONE INFORMED CONSENT FORM

Name of Participant:

_____ _____ _____
Last Name First Name Middle Initial

_____ ◯ Male ◯ Female _____
Date of Birth (Month/Day/Year) Participant's ID Number

It is important that you read the following. If there is anything that you do not understand, or if you have any questions, be sure to ASK.

Welcome to Cornerstone, a system that collects data on a wide range of health care services to individuals. These services include WIC (Women, Infants and Children); Immunizations; Case Management; Prenatal and Postpartum Care; Pediatric Primary Care; Early Intervention; Breast and Cervical Cancer; Diabetes Control; Healthy Families Illinois; and Family Health History Questionnaire/Genetics.

We are asking for permission to collect information about the participant and store it in a centralized computer system maintained by the Illinois Department of Human Services and Public Health. Based on the information collected during the enrollment or registration process, we will determine whether you need further service. Only those authorized health care professionals with a direct need to know about you will have access to this information. Information may be released for service authorization, audit, and evaluation purposes. Necessary information, without any client s name, will be sent to federal agencies that fund these programs.

By signing this consent form, you agree to allow certain information to be collected by this agency/clinic. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private, and not release it to anyone else without your written permission unless the law allows it.

A. I authorize Calhoun County Health Department to collect information during the enrollment/registration process.
B. This authorization covers all the medical, social and financial information about the participant, including: participant background and demographic information; health visit information; medical and developmental history; prenatal; birth, and postpartum data; infant/child visit data; immunization records; participant risks; problems or factors that prevent the participant from receiving proper medical care; appointments made and services received; goals and care plan; WIC food packages; program information; information required by the federal Maternal and Child Health Block Grant Program; and Early Intervention. Any information you do not want released should be written in Part D.
C. This authorization also covers information about mental health, AIDS, HIV, sexually transmissible diseases, alcoholism, and drug use which may be reported by me. I understand that I am not required to report or discuss those matters with anybody.
D. The following information I do NOT want to be shared;
E. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done before I revoked it. I also understand and agree not to hold the Illinois Department of Human Services and Public Health liable for the release of any information about me in accordance with the terms of this consent form.
F. A photostatic copy/facsimile of this consent will be as valid as the original.

For Child Participant: **OR** **For Adult Participant:**

_____ _____
Signature of parent/legal guardian/caretaker/Date Signature of adult participant/Date

Do you want the child's physician notified of the vaccines given today? ◯ Yes ◯ No Dr. Name: _____

Signature of Witness: _____