Village of Hoffman Estates
Department of Health and Human Services
1900 Hassell Road
Hoffman Estates, IL 60169

CHILDREN 6 months-18 years old SEASONAL INFLUENZA VACCINE

Child's Name: _____ Birth Date: _____ Age: ___ Sex: M F
FIRST MI LAST

Address: _____City: _____, IL Zip: _____

Phone #: _____Email: _____

Amount Paid: $_____ Cash, Check, Credit or Medicaid #: _____

Credit Card #: _____ Exp. Date: ____ /____ CVV Code: _____

Parent's Name: _____

Please read the following questions carefully and check "YES" or "NO"

□**YES** □**NO** 1. Is your child sick today with any mild to moderate illness or other active infection?

□**YES** □**NO** 2. Has your child or anyone in your household been diagnosed with COVID-19?

If so, when? _____

□**YES** □**NO** 3. Has your child had symptoms of COVID-19 with or without a test in the past 14 day?

(fever, chills, cough, shortness of breath, fatigue, muscle aches, headaches, new loss of taste or smell, sore throat, nasal congestion, nausea, vomiting, diarrhea, pink eye, rashes or red swollen toes)

□**YES** □**NO** 5. Is your child allergic to chicken eggs, or any component of the flu vaccine?

□**YES** □**NO** 6. Has your child ever had a serious reaction to the flu vaccine before?

□**YES** □**NO** 7. Is your child pregnant? If so, a prescription from your doctor is required.

□**YES** □**NO** 8. Has your child ever been diagnosed with Guillain-Barre syndrome?

How many flu shot has your child received in the past? □ None □ One □ 2 or more

NOTES: _____

I have received and read or have had explained to me the Inactivated Influenza Vaccine Information Statement Sheet (08/15/2019) about the vaccine that will be administered. I understand the risks of the vaccine that will be given to me or to the person named above for whom I am authorized to make this request, and I hereby release and hold harmless the Village of Hoffman Estates from all responsibility for any reaction that may occur from the immunization against SEASONAL INFLUENZA (FLU). **I will take responsibility to seek medical attention should any severe symptoms occur**. I also understand that the Village of Hoffman Estates will use identifying information about me if they need to submit a bill for reimbursement.

X_____ Date_____

Signature (of vaccine recipient or person authorized to make request)

FOR OFFICE USE ONLY. This form validated with RN signature and Village stamp.

Form Revised 9/21/20

RN Signature: _____
Temperature: _____ Deltoid Site: R L
Stamp:_____
Data Entry: □VOHE

□ Sanofi Pasteur Fluzone (QIV) MDV 0.5 ml
□ Sanofi Pasteur Fluzone (QIV) PF 0.5 ml
□ GlaxoSmithKline Fluarix (QIV) PF 0.5 ml 9A235 exp: 6/30/2021
Sticker: