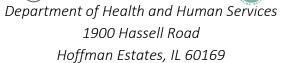


## W Village of Hoffman Estates







## CHILDREN 6 months-18 years old SEASONAL INFLUENZA VACCINE

					-	
Child's Name:			Birth Date:	Age:	Sex: M F	
		FIRS1 MI				
Phon	ie #:		Email:			
Amo	unt Paid	d: \$ Cash, Check, Credi	t or Medicaid #:			
		#:				
		☐ Underinsured ☐ Medicaid ☐ N				
		e following questions carefully and				
□YES						
□YES	□NO	Has your child or anyone in your household been diagnosed with COVID-19?				
	2	If so, when?	_		.5 13.	
□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, runny nose, nausea, vomiting, diarrhea, pink eye, rashes or red swollen toes)				
□YES	□NO	4. Is your child allergic to chicken eggs, or any component of the flu vaccine? (Chicken productsegg albumins/proteins, chickens, chicken feathers or dander, Formaldehyde, Gelatin, Octoxynol-10/Octylphenol Ethoxylate (Triton X-100), Sodium phosphate-buffered isotonic sodium chloride solution, Thimerosal, Sodium Deoxycholate, a-Tocopheryl Hydrogen Succinate, Polysorbate 80, Gentamicin, Hydrocortisone)				
□YES	□NO	5. Has your child ever had a serious reaction to the flu vaccine before?				
□YES	□NO	6. Is your child pregnant? If so, a prescription from your doctor is required.				
□YES	□NO	7. Has your child ever been diagnosed with Guillain-Barre syndrome?				
How m	any flu	shot has your child received in th	e past?   None   One	2 or more		
about th for whor responsi <b>seek me</b>	ceived an e vaccine n I am au bility for a dical atte	d read or have had explained to me the lithat will be administered. I understand the thorized to make this request, and I herekany reaction that may occur from the imminion should any severe symptoms occur me if they need to submit a bill for reimless.	ne risks of the vaccine that will be by release and hold harmless the nunization against SEASONAL INF r. I also understand that the Villa	e given to me or Village of Hoffm LUENZA (FLU). I	to the person named above an Estates from all will take responsibility to	
X			Date			
Signatur	<b>e</b> (of vacc	ine recipient or person authorized to mak	ke request)			
FOR OF	FICE USE	ONLY. This form validated with RN sign	nature and Village stamp.		Form Revised 9/28/21	
RN Signature:  Site: R L Deltoid / Thigh IM  Stamp:  Covid Screening/Temperature:			□ VFC Sanofi Pasteur Fluzone (QIV) SDV 0.5 ml U7328AA Expires 06/30/202 □ Sanofi Pasteur Fluzone (QIV) PF 0.5ml UT7315NA Expires 06/30/22 □ GlaxoSmithKline Fluarix (QIV) PF 0.5ml PH7C2 Expires 06/30/2022 Data Entry: □ I-CARE			