#### **Village of Hoffman Estates**

#### Department of Health and Human Services

#### 1900 Hassell Road

#### Hoffman Estates, IL 60169

# **SEASONAL INFLUENZA VACCINE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_ Sex: M F

FIRST MI LAST

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, IL Zip: \_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount Paid: $\_\_\_\_\_\_\_ Cash, Check, Credit or Medicare Part B #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date: \_\_\_\_ /\_\_\_\_ CVV Code: \_\_\_\_\_\_

□ VOHE EMPLOYEE □ VOHE FAMILY/PARK DISTRICT/TOWNSHIP EMPLOYEE

Please read the following questions carefully and check “YES” or “NO”

**□YES □NO** 1. Are you sick today with any mild to moderate illness?

**□YES □NO** 2. Have you or anyone in your household been diagnosed with COVID-19? If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□YES □NO** 3.Have you 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, or diarrhea)**

**□YES □NO** 4. Are you allergic to latex, chicken eggs, or any component of the flu vaccine?

**(Chicken products--egg 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. Have you had a serious reaction to the flu vaccine before?

**□YES □NO** 6. Are you pregnant? If so, a prescription from your doctor is required.

**□YES □NO** 7. Have you ever been diagnosed with Guillain-Barre syndrome?

NOTES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have received and read or have had explained to me the Inactivated Influenza Vaccine Information Statement Sheet (08/06/2021) 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)

Form Revised 9/15/2021

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

**□ Sanofi Pasteur Fluzone (QIV) MDV 0.5ml UJ705AA Expires 06/30/22**

**□ Sanofi Pasteur Fluzone (QIV) PF 0.5ml UT7315NA Expires 06/30/22**

**□ GlaxoSmithKline Fluarix (QIV) PF 0.5ml PH7C2 Expires 06/30/22**

**□ Sanofi Pasteur Fluzone** High-Dose **(QIV) PF 0.7ml UJ731AB Expiration 06/30/22**

Injection Site: Deltoid R L **IM**

Temperature: \_\_\_\_\_\_\_\_\_

RN Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stamp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Data Entry: □ VOHE □ I-Care

Sticker: