



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: _____
 Uninsured Underinsured Medicaid Native Alaskan/American Medi Check: _____

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, 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 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. 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 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 (08/06/2021) 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)

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

Form Revised 9/19/22

RN Signature: _____ Site: R L Deltoid / Thigh IM Stamp: _____ Covid Screening/Temperature: _____	<input type="checkbox"/> VFC Sanofi Pasteur Fluzone (QIV) SDV <input type="checkbox"/> Sanofi Pasteur Fluzone (QIV) PF 0.5ml <input type="checkbox"/> GlaxoSmithKline Fluarix (QIV) PF 0.5ml Data Entry: <input type="checkbox"/> I-CARE
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