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)

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

Form Revised 9/13/2022

Injection Site: Deltoid R L **IM**
Temperature: _____
RN Signature: _____
Stamp: _____
Data Entry: □ VOHE □ I-Care

□ Sanofi Pasteur Fluzone (QIV) MDV
□ Sanofi Pasteur Fluzone (QIV) PF
□ GlaxoSmithKline Fluarix (QIV) PF
□ Sanofi Pasteur Fluzone **High-Dose** (QIV) PF