Macoupin County Public Health Department

Maple Street Clinic-Gillespie, IL **Morgan Street Clinic-Carlinville, IL**

Dear Parents,

A convenient program will soon be available in your child's school. Maple Street Clinic, Morgan Street Clinic, Macoupin County Public Health Department, and the Illinois Department of Healthcare and Family Services have been arranged for certain dental, medical and counseling services for eligible children. **ALL students regardless of income are eligible for these services.** Services may include a school or sports physical, immunizations, sick/urgent care, dental care, and counseling. In order for your child to receive these services, please fill out this form and return it to your child's school nurse. If you or any family member are in need of these services, they are also available for adults at our facilities in Carlinville or Gillespie.

Please print IN INK and answer ALL the following questions:

SCHOOL: _____ TEACHER _____ GRADE _____

CHILD'S NAME: _____ BIRTHDATE: _____ GENDER: M / F

ADDRESS: _____ CITY/ZIP _____

PHONE: _____ HOUSING: ☐ **Public Housing** ☐ **Rent** ☐ **Own** ☐ **Other**

EMAIL ADDRESS: _____ ETHNICITY: ☐ **Hispanic** ☐ **Non-Hispanic** ☐ **Other** ☐ **Many**

RACE: Please check all that apply for your child ☐ **Asian** ☐ **Black** ☐ **Hispanic** ☐ **Native American** ☐ **White** ☐ **Other**

Does your child qualify for free/reduced lunch? ☐ **Yes** ☐ **No** Is your child enrolled in the "All Kids" or Medical Card? ☐ **Yes** ☐ **No**

If **YES**, what is your child's recipient number (9 digits): ____-____-____-____-____-____-____-____-____-____-____

Other Insurance Name: _____ Policy #: _____

Group #: _____ Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

HEALTH HISTORY

Has your child had any serious health problems? ☐ **YES** ☐ **NO**

If **YES**, please explain _____

Does your child have any allergies? ☐ **YES** ☐ **NO**

If **YES**, please explain _____

Is your child taking any medications at this time? ☐ **YES** ☐ **NO**

If **YES**, please list _____

Emergency Contact: _____ Phone number: _____

The above is true and correct to the best of my knowledge. All clients have the right to treatment by Macoupin County Public Health Department, Morgan Street Clinic and Maple Street Clinic without discrimination to age, race, color, religion, sex, sexual orientation or national origin. I accept full responsibility for my care and treatment and release MCPHD, Maple Street Clinic, and Morgan Street Clinic and staff of any and all liability for any adverse results that may occur due to my refusal to follow the recommended plan of treatment. I authorize Macoupin County Public Health, Morgan Street Clinic and Maple Street Clinic to provide service to me and to release necessary information to bill, process, and receive payment of Medical/Behavioral/Dental Benefits (private insurance, Medicare, Medicaid, etc.), for Professional Services rendered. I give permission for IDPH, QA audits to be performed and providers to return to check my child's sealants and for the school nurse and providers access to the child's dental record or medical record.

Parent/Guardian Signature: _____ Date: _____

Print Parent/Guardian Name: _____

Parent/Guardian Date of Birth: _____ Relationship _____

Maple Street Clinic and Morgan Street Clinic School-Linked Health Center

Patient Name: _____ Date of Birth: _____

Available services include, but are not limited to:

- Physical examination, health assessments, screening for health problems
- Diagnosis and treatment of acute illness and injury
- Immunizations, Lead, Hemoglobin, and TB skin tests
- Diagnosis and management of chronic illness
- Health education and promotion. Outreach health promotion/prevention workshops will be offered
- Laboratory tests including throat cultures, complete blood counts, mono spots, etc.
- Wellness promotion including smoking cessation, nutrition, weight management
- Reproductive health care including: gynecological examinations with PAP smears, STD education, testing and treatment, HIV/AIDS education, counseling/testing, and contraceptive services
- Mental Health counseling services
- Dental examination and treatment
- Referrals to other linkage agencies for services not provided at the School Health Center

Please select the service(s) you (parent or legal guardian) give consent for:

Dental
___**All services below**
___Sealants
___Fluoride
___Prophy(cleaning)
___Exams & treatment
___Decline services

Medical
___**All services below**
___Immunizations
___Lead/Hemoglobin test
___TB skin test
___School/sports physicals
___Treatment for acute illness/injury
___Reproductive health care
___Decline services

Mental Health
___Counseling
___Decline services

Please give my child vaccinations that will make him/her compliant with Illinois State School Requirements.

Parent/Guardian _____

In addition to the Illinois State School Required Immunizations, please give my child vaccinations that are recommended by the American Pediatric Association.

Parent/Guardian _____

Parental Consent **PUBLIC ACT100-378 Consent by Minors to Health Care Services Act**

The above-named student has my consent to receive services offered by the Macoupin County Maple Street School-Linked Health Center, Gillespie, IL and Morgan Street School-Linked Health Center, Carlinville, IL. I have been informed of and understand the scope of services which may be provided to the student. I understand that under Illinois law, a minor age twelve (12) and over has the same capacity as an adult to consent to certain health services and no parental permission is required for such services. I understand that if my child is 12 or older and were to receive mental health/substance abuse services at Maple Street School -Linked Health Center and Morgan Street School-Linked Health Center, he/she may receive up to eight (8) therapy sessions without my consent. I am aware that a separate parental consent form will need to be signed for substance abuse services. By law, a child under the age of twelve (12) will not be allowed to receive mental health/substance abuse services without parental consent.

I also consent to the release of relevant health information to the Macoupin County Maple Street Clinic and Morgan Street Clinic in order to facilitate evaluation of my child's health needs. I further authorize the School-Linked Health Center to release information regarding my child's treatment to third-party payers or others for the purposes of billing, program management, and evaluation in accordance with federal and state laws and regulations regarding confidentiality. I further authorize my child's school district to release to the School-Linked Health Center regarding my child's address and phone number for the purpose of maintaining the School-Linked Health Center's database.

I understand that I may revoke this consent in writing at any time, but that revoking this consent will not cancel what was done before I revoked the consent. I also understand that I have the right to refuse services at any time.

_____ _____
(Signature of parent/guardian) (Date signed)

_____ _____
(Signature of patient 12 yrs or older) (Date signed)

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CONSENT TO TREATMENT FOR A CHILD

Maple Street Clinic requires that all parent/legal guardians bring their child to their first appointment. This is necessary to complete all forms and to sign consent for treatment. Consent to treatment allows those names listed to bring the child to our facility for treatment. However, a parent/legal guardian must bring the child to any appointment requiring an extraction in dental or a medication change in behavioral health. The below named individual(s) will provide information regarding my child's health, allergies, immunization contraindications, previous reactions to immunizations, and all medication currently being taken. The staff at Maple Street Clinic and Morgan Street Clinic (School Linked Health Centers) has my permission to treat my child and/or provide all needed immunizations, dental, medical, behavioral health care.

I understand that this form must be updated once per year.

Please sign the following consent if your child may be brought to his/her appointment by another adult (over 18 years of age).

I, _____**, hereby give my consent for treatment and/or immunizations of**
(Parent/Legal Guardian)

_____ **DOB** _____ **by the staff at Maple/Morgan Street Clinics.**
(Child's Name)

I give the consent for the following adults to bring my child to his/her medical, dental, or behavioral health appointments:

1. _____ _____
(Name of adult) (Relationship to child)

2. _____ _____
(Name of adult) (Relationship to child)

3. _____ _____
(Name of adult) (Relationship to child)

_____ _____
(Signature of Parent or Legal Guardian) (Date)

_____ _____
(Witness) (Date)

Vaccination Fee (Check only One Box)

My Child:

☐ Is enrolled in Medicaid. Child's Medicaid#_____

☐ Does not have Health Insurance (Fee $10 per vaccine)

☐ Has Health Insurance which does not pay for vaccines (Fee $10 per vaccine)

☐ Is American Indian or Alaska Native (No fee)

☐ Has Health Insurance that pays for vaccines

Vaccines for Children (VFC) is a federal program providing vaccines for children 18 years and under who qualify. Those who qualify will not be refused service due to their inability to pay. Those who have insurance that pays for their vaccine do not qualify for this program.

We will bill your insurance company for vaccines received here today.

Physical Exam Fee (Check only One Box)

My Child:

☐ Is enrolled in Medicaid. Child's Medicaid#_____

☐ Does not have Health Insurance (Fee $25 for physical)

☐ Has Health Insurance and has seen primary care for a well check within the 12 months (Copay or $25 for physical, whichever one is less) – Insurance will only pay for one well check in 12 months.

☐ Has Health Insurance and has ***NOT*** seen primary care for a well check within the 12 months (No Fee) – Insurance will pay for one well check in 12 months.

Last	First	Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)	Yes / No	List:		**MEDICATION** (Prescribed or taken on a regular basis.)	Yes / No	**List:**	
Diagnosis of asthma?	Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Child wakes during night coughing?	Yes No						
Birth defects?	Yes No			Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No			Surgery? (List all.) When? What for?	Yes No		
Diabetes?	Yes No			Serious injury or illness?	Yes No		
Head injury/Concussion/Passed out?	Yes No			TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
Seizures? What are they like?	Yes No			TB disease (past or present)?	Yes* No		
Heart problem/Shortness of breath?	Yes No			Tobacco use (type, frequency)?	Yes No		
Heart murmur/High blood pressure?	Yes No			Alcohol/Drug use?	Yes No		
Dizziness or chest pain with exercise?	Yes No			Family history of sudden death before age 50? (Cause?)	Yes No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes No			Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes No						

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed** ☐ **Skin Test: Date Read** **Result: Positive** ☐ **Negative** ☐ **mm**_____

Blood Test: Date Reported **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** **Yes** ☐ **No** ☐ **Modified** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?	☐	☐	☐
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (4/19)

Updated 05/26/2020

Maple Street Clinic
109 E. Maple
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Macoupin County
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INFORMATION ABOUT PERSON TO RECEIVE VACCINE
(PLEASE PRINT)

LAST NAME:_____ **FIRST NAME:** _____ **MI:**____ **SEX: M F**

STREET:_____ **CITY:** _____ **ST:**____ **ZIP:**_____

COUNTY:_____ **DOB:**_____ **AGE:**_____ **DR. NAME:**_____

MEDICAID/MEDICARE #:_____ **INSURANCE INFO:**_____

I have read or have had explained to me the information contained on the Vaccine Information Sheet about the vaccine(s) that will be administered. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) checked be given to me or to the person named above for whom I am authorized to make this request. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I have had an opportunity to view a copy of Macoupin County Public Health Department's NOTICE OF PRIVACY PRACTICES.

PARENT'S NAME (print) _____ **PARENT'S BIRTHDATE**_____

Signature of person to receive vaccine or person authorized to make request.

X_____ **DATE**_____ **PHONE**_____

VACCINE IMMUNIZATION RECORD

	VIS DATE	MANUFACTURER	LOT #	EXP. DATE	DOSE #	ADMINISTRATION SITE
DTAP/DAPTACEL	VIS 04-01-20	SANOFI				
DTAP/INFANRIX	VIS 04-01-20	GSK				
IPV/IPOL	VIS 10-30-19	SANOFI				
DTAP-IPV-HEP B/PEDIARIX	VIS 04-01-20	GSK				
HIB/ACT HIB	VIS 10-30-19	SANOFI				
HIB/HIBERIX	VIS 10-30-19	GSK				
PCV13/PREVNAR	VIS 10-30-19	PFIZER				
ROTA VIRUS/ROTARIX	VIS 10-30-19	GSK				
HEP A/HAVRIX	VIS 07-20-16	GSK				
HEP B/ENGERIX	VIS 08-15-19	GSK				
MMR	VIS 08-15-19	MERCK				
VARICELLA/VARIVAX	VIS 08-15-19	MERCK				
DTAP-IPV/KINRIX	VIS 04-01-20	GSK				
MMRV/PROQUAD	VIS 08-15-19	MERCK				
T-DAP/BOOSTRIX	VIS 04-01-20	GSK				
MCV4/MENVEO	VIS 08-15-19	GSK				
HPV/GARDASIL 9	VIS 10-30-19	MERCK				
PNEUMO 23/PNEUMOVAX	VIS 10-30-19	MERCK				
TD/TENIVAC	VIS 04-01-20	SANOFI				
MEN B/BEXSERO	VIS 08-15-19	GSK				

DATE: _____ **AGE:** _____ **NURSE'S SIGNATURE:** _____

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217-839-1538 - FAX
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Macoupin County
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1115 Morgan Street, Carlinville, IL 62626
Medical/Behavioral - 217-854-3692
FAX – 217-930-2293
Dental - 217-854-6823

Vaccines for Children (VFC) Program
Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 3 years or longer depending on state law. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. **Child's Name:** _____
   Last Name **First Name** **MI**

2. **Child's Date of Birth:** __ __ / __ __ / __ __ __ __

3. **Parent/Guardian/Individual of Record:** _____
   Last Name **First Name** **MI**

4. **Primary Provider's Name:** _____
   Last Name **First Name** **MI**

----------↓↓↓ FOR OFFICE USE ONLY ↓↓↓----------

5. **To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the VFC and state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category.** ***If Column A-D is marked, the child is eligible for the VFC program. If column E, F or G is marked the child is not eligible for federal VFC vaccine.***

	Eligible for VFC Vaccine				Not eligible for VFC Vaccine		
	A	B	C	D	E	F	G
Date	Medicaid Enrolled Title XIX (19) (V02)	No Health Insurance (V03)	American Indian or Alaskan Native (V04)	*Underinsured served by FQHC, RHC or deputized LHD (V05)	Has health insurance that covers vaccines (V01)	**Other underinsured (V01)	***Enrolled in CHIP Title XXI (21) or State Funded (V22)

***Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*

***Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*

****Children enrolled in a separate state Children's Health Insurance Program (CHIP) Title XXI (21) or State Funded. These children are considered insured and are not eligible for vaccines through the VFC program. Effective 09/01/2019, CHIP covered children must receive CHIP vaccines distributed through the VFC program.*

FOR PRE-K AND KINDERGARTEN STUDENTS ONLY

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

PEDIATRIC TB RISK ASSESSMENT FORM

Physician/ Health Provider:	Phone:	Date:

Child's Name: _____ Date **of Birth:** ____/____/____

Address: _____ **City:** _____ **State:** _____ **County:** _____

Sex: ❒Male ❒Female **Hispanic:** ❒No ❒Yes **Race:** ❒White ❒Black ❒Asian ❒Am. Indian/Nat. Alaskan ❒Other _____

US Born: ❒Yes ❒No **If no, US Date of Arrival:** ____/____/____ **Country of Birth:** _____

Parent/Guardian: _____ **Phone:** _____

TB RISK FACTORS:

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray?	❒Yes ❒No	If yes, name of symptoms: _____
2. In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?	❒Yes ❒No	
3. Was the child born in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East?	❒Yes ❒No	If yes, in what country was the child born: _____
4. Has the child lived or traveled in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East for more than one month?	❒Yes ❒No	If yes, in what country did the child travel to: _____
5. Have any members of the child's household come to the United States from another country?	❒Yes ❒No	If yes, name of country: _____
6. Is the child exposed to a person who: • Is currently in jail or who has been in jail in the past 5 years? • Has HIV? • Is homeless? • Lives in a group home? • Uses illegal drugs? • Is a migrant farm worker?	❒Yes ❒No	If yes, name the risk factors the child is exposed to: _____ _____
7. Is the child/teen in jail or ever been in jail?	❒Yes ❒No	If yes, name of jail: _____
8. Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	❒Yes ❒No	If yes, name of disease or medications: _____

If yes, to any of the above, the child has an increased risk of TB infection and should have a TST/IGRA.

All children with a positive TST/IGRA result must have a medical evaluation, including a chest X-ray. Treatment for latent TB infection should be initiated if the chest X-ray is normal and there are no signs of active TB. If testing was done, please attach or enter results on next page.

Registration Date: _____

Updated 12/17/20

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COVID-19 Vaccine Administration Record

INFORMATION ABOUT PERSON TO RECEIVE VACCINE

Please Print:

Last Name:_____ First Name:_____ MI:_____

Gender: ☐ Male ☐ Female Date of Birth:_____/_____/_____ Age:_____

Address:_____
(Street Address) (City) (State) (Zip)

County:_____ Phone Number: _____

Email Address:_____ Occupation:_____

Emergency Contact:_____ **Phone Number:** _____

Race: ☐ Asian/Pacific Islander ☐ African American/Black ☐ Native American ☐ White ☐ Other/Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

I have read or have had explained to me the information contained on the EUA Fact Sheet for Recipients and Caregivers regarding the COVID-19 vaccine that will be administered. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine and ask that the COVID-19 vaccine be given to me or to the person named above for who I am authorized to make this request. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I have been given an opportunity to read the Notice of Privacy Practices for the Macoupin County Public Health Department and to have any questions answered before signing.

Signature of person to receive the vaccine or person authorized to make the request:

Printed Name:_____ **Relationship to patient:** _____

Signature: _____ **Parent/Guardian DOB:** _____ **Date:** _____

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COVID-19 Vaccine Administration Record

Manufacturer (Circle one):	Pfizer	Moderna	Other:
Lot Number:			
Expiration:			
Site Administered (Circle one):	Right Deltoid	Left Deltoid	Other:
Date Administered:			
Administered by:			

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• Did you bring your vaccination record card or other documentation? *(yes/no)*	☐	☐	
3. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following:			
o Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer)
- ☐ Take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of herparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists