Health4Chicago

Immunizer: Internal use only
LOT #:

ADULT FORM: Pertussis & Flu Vaccination

This form is to be filled out for ADULTS ONLY

BASIC INFORMATION

Last Name:	First Name:	
Date of Birth: / /	Sex: ☐ M ☐ F	Employer:
Home Address:		ZIP Code:
Daytime phone:	Mobile phone:	Are other members in your family getting immunized at this clinic? ❑ Children ❑ Spouse
Email address:		

SCREENING INFORMATION

Please provide the following information to help us determine your eligibility for vaccination:

Have you ever had a **severe** reaction to a vaccine? ❑ No ❑ Yes- describe:

Do you have any **severe** allergies to medications, food, **eggs**, or latex? ❑ No ❑ Yes- describe:

Do you have a condition that lowers immunity (cancer, leukemia) ❑ No ❑ Yes- describe:

Are you taking medication that lowers immunity (cortisone, other steroids, radiation)? ❑ No ❑ Yes- describe:

Are you currently receiving aspirin therapy? ❑ No ❑ Yes- describe:

Have you ever been diagnosed with asthma or experienced recurrent wheezing? ❑ No ❑ Yes- describe:

Are you pregnant or nursing? ❑ No ❑ Yes

Please let us know about any changes in your medical condition on the day of vaccination.

VACCINATIONS TO BE ADMINISTERED

I have read and understand the information provided to me about the vaccinations listed below, including risks and side effects. I would like to receive the vaccinations listed below. I further understand the School that my child attends (named above) is not liable for the services or vaccinations administered by Health4Chicago.

I would like to receive the recommended vaccine(s) I have checked below:

❑ Seasonal Influenza (Flu) vaccine ❑ Diphtheria, Tetanus and Pertussis (Tdap) vaccination

FLU VACCINE FORM PREFERENCE (ONLY FLU HAS THIS OPTION)

◯ Please use the intramuscular flu shot (shot in arm) ◯ Please use the nasal spray flu vaccine (spray in nose)

INSURANCE INFORMATION

Insurance:	Insured's Name:
Insurance ID #:	Group #:
Insured's Date of Birth:	Employer Name:
Employer Address:	Employer Phone:

I opt out of my information being entered into the Illinois Comprehensive Automated Immunization Registry Exchange, which allows Illinois providers access to my immunization records. ❑

I agree to assign insurance benefits to the treating physician. Medical information may be released to my insurance company for the purposes of securing payment for services received. I understand it is my responsibility to understand my benefits and insurance coverage and I will be held responsible for any fees owed for services.

_____ _____

Signature **Date**