HEALTH 4 CHICAGO

UNIVERSITY OF CHICAGO • UNIVERSITY OF ILLINOIS

FLU VACCINATIONS

INFORMATION

Last Name: First Name:

Date of Birth: ❑Male ❑ Female Clinic Location: Lab School

Home Address: ZIP Code:

Daytime Phone: (Required) Mobile: (Optional)

Email address (If available):

HEALTH SCREENING

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) or take medication that lowers immunity (cortisone, other steroids, radiation)? ❑ No ❑ Yes- describe:

Please check with your doctor if you are unsure of medical details. Please let us know about any changes in your medical condition on the day of vaccination.

CONSENT FOR VACCINATION

I have read and understand the information provided to me about the vaccinations listed below, including risks and side effects. 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 Shot (Flu)______ ❑ Seasonal flu (Flumist)_________

❑ Tdap ❑ Other Vaccine:_________________________

HEALTH INSURANCE ❑ I DO NOT HAVE INSURANCE

Name of Insured: Insured's Date of Birth:

Medicare #:

Insurance Type (non-Medicare): ❑ PPO ❑ HMO

Insurance ID #: Group #:

Employer Name:

INTERNAL USE ONLY

Vaccine	Date Administered	Site/ Route (Circle One)	Lot Number	Immunizer
Influenza vaccine	10/ /2018	RA IM LA IM IN		Health4chicago
		RA IM LA IM IN		
		RA IM LA IM IN		

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**