UNIVERSITY OF ILLINOIS SPRINGFIELD
Campus Health Service • BSB 20 • (217) 206-6676 • Fax (217) 206-7779

INFLUENZA VACCINE CONSENT & ADMINISTRATION RECORD

Provide the following information about person to receive vaccine *(Please Print)*:

NAME ______________________________ DATE OF BIRTH ____________
Last First M.I.

ADDRESS ______________________________ AGE ____________
Street

____
City State Zip County

TELEPHONE (daytime) (_____) ______________ EMAIL ______________

SOCIAL SECURITY NUMBER (last 4 digits only) ______________

With respect to your social security number, note the following. The provision of a flu shot is a gratuitous one being made available to you by your employer. You do not have to participate. If you do, we request that you provide us with the last four digits of your social security number so that your bill when submitted can be readily identified and paid. The request for the last four digits of your social security number is voluntary in nature and is not mandated by any statute. These digits, along with the other information on this form, will be used to facilitate prompt payment to the health care provider and in any other manner consistent with HIPAA, state and federal statute and regulations. Thereafter, information will be kept confidential as required by HIPAA and all other state and federal statutes and regulations. If you choose not to disclose the last four digits of your social security number, please provide either your home address and/or date of birth.

Have you been a patient in Campus Health Service before? ❑ Yes ❑ No

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The clinic may keep this record in your medical file or your spouse's medical file. They will record what vaccine was given and the date administered, the name of the company that made the vaccine and the special lot number, the signature and title of the person who administered the vaccine and the location where the vaccine was given.

"I have read or have had explained to me information provided by Campus Health Service regarding influenza and the influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits as well as the risks of the influenza vaccine, and have given permission to have the vaccine administered to me."

SIGNATURE X ______________________________ DATE ______________

For Clinic / Office Use Only

Site Location: UIS ❑ Staff ❑ Student ❑ IL State Employee / Retirees ❑ Other ______________

__________ Clinic __________ Satellite

Date Vaccine Administered: _____ /_____ / 2011 Site of Injection: R / L Deltoid

Vaccine Manufacturer: Glaxo-Smith Kline Vaccine Lot Number: AFLUA608AA Exp. 6/10/12

Signature of Vaccine Administrator: ______________________________

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