Lawrence County Health Department – Public Health Clinic
2101 James Street, Lawrenceville, IL 62439 (618) 943-3302

FLU SEASON 2026-2027

*** ARE YOU ALLERGIC TO EGGS OR THIMEROSAL? TELL THE NURSE IF YOU ARE ***

Print name as shown EXACTLY on Medicare Card: (If applicable)

NAME: _____ _____ _____ **SEX:** M F
First MI Last

DATE OF BIRTH: _____ / _____ / _____ **AGE:** _____
Month Day Year

PRIMARY PHONE: _____

STREET ADDRESS: _____

CITY / STATE / ZIP: _____

- I have read or have had explained to me the information in the Vaccine Information Statement about influenza and influenza vaccines.
- I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request.
- I, the undersigned, voluntarily agree to have the influenza vaccine given to me (or the person named above). The person receiving this vaccine is in good health currently and is not allergic to chicken egg products or Thimerosal. I understand that a physician consult is necessary prior to taking the vaccine for persons who have a history of Guillain – Barre syndrome or have ever had a serious allergic reaction or other problems after getting an influenza vaccination.
- I consent to allow information on this form, as well as the patient registration form, to be entered as necessary into the IL Department of Human Services and Public Health's Cornerstone computer system, the Illinois Immunization Registry (ICARE) and LCHD's electronic billing system.
- I will not hold the Lawrence County Health Department or the nurse giving the vaccine responsible for any adverse reaction that may result from this vaccination.
- I authorize the release of any information necessary to process a Medicare, Medicaid, or health insurance claim if applicable. I request payment of benefits to the Lawrence County Health Department.
- I have been provided with the Notice of Privacy Practices

SIGNATURE: _____ **DATE:** _____

INSURANCE INFORMATION: ***** PLEASE PRESENT INSURANCE CARD(S) TO CLERK *****

Medicare Part B – Primary ID#: _____
Write name exactly how it appears on Medicare Card: _____

Insurance Co.: _____ **ID#:** _____ **Group#:** _____
Name of Policy Holder: _____ **Date of Birth:** _____
Social Security: _____
Address of Policy Holder (if different from patient): _____

Do you also have Medicaid? Y N **If Yes, do you pay a premium? Y N**
If Yes, enter Medicaid ID#: _____ **(9-digit number beside name on Medicaid Card)**

Do you have Secondary Insurance? Y N **If Yes, Insurance Co. Name:** _____

**** ATTENTION: LCHD will bill health insurance, Medicare Part B, and Medicaid. If your claim is denied you will be billed for the flu vaccine. If you do not have insurance, Medicare, or Medicaid, please pay the required fee today. ****

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FOR OFFICE USE ONLY

Private Pay: 6 months – 64 Years Old **Private Pay: 65 Years+ (HIGH DOSE)**

_____ NOT VFC ELIGIBLE DUE TO AGE OR INSURANCE STATUS

VFC: 6 months – 18 Years Old **Mark Eligibility Reason Below:**

_____ VFC Eligible Reason: ___ Medicaid ___ No Insurance ___ Under Insured ___ Other: _____

___ Paid Cash ___ Bill Private Insurance ___ Bill Medicare

___ Bill Medicaid # _____ ___ Check Medi _____ Title _____

___ Billed through VaxCare ___ Check EMD's Clerk Initials: _____

NURSE USE ONLY

Second Dose Required (on children 6 months – 8 years): ___ YES ___ NO

Vaccine Information (write in / place sticker here):

Manufacturer:

Lot #: **Vaccine Info. Sheet Offered? _____**

Expiration Date: 01/31/2025 or Most Current

Dosage:

SITE: ___ Left Thigh ___ Right Thigh ___ Left Deltoid ___ Right Deltoid

FACILITY: _____

NURSE SIGNATURE: _____ **DATE:** _____

ICARE Entry Date: _____ Initials: _____