Adult Vaccine Request Form

1002 East Laurel Ave, Havana, IL 62644 ▪ Phone: (309) 210-0110 ▪ Fax: (309) 543-2063

Patient's Name: ________________________________ Date of Birth: ____/____/____

Question	Response
1. Do you have any allergies to medications, foods, or latex?	☐ No ☐ Yes ☐ Don't Know If Yes: ______________________ ______________________________
2. Have you ever had a serious reaction to a vaccine in the past?	☐ No ☐ Yes ☐ Don't Know
3. Do you have any long-term health problems?	☐ No ☐ Yes ☐ Don't Know If Yes: ______________________ ______________________________
4. In the past 6 months, have you taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; had radiation treatment; been on long-term aspirin therapy?	☐ No ☐ Yes ☐ Don't Know
5. Have you ever felt dizzy or faint before or after a shot?	☐ No ☐ Yes ☐ Don't Know
6. Are you pregnant or is there a chance you could become pregnant during the next month?	☐ No ☐ Yes ☐ Don't Know

I have received a copy of the Vaccine Information Statement for each vaccine being requested and have had the opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or the person named above for whom I am authorized to make this request.

Patient's or Authorized Person's Signature: ________________________________ Date: ___________

OFFICIAL USE ONLY

	DTP	HAV	HBV	HPV	FLU	MMR	MCV4
Mfgr.							
Lot #							
Dosage							
Site/Route							
VIS Given	8/6/21	1/31/25	1/31/25	8/6/21	8/6/21	1/31/25	1/31/25

	MEN B	PCV	POL	RSV	VAR	ZOS	COVID
Mfgr.							
Lot #							
Dosage							
Site/Route							
VIS Given	1/31/25	5/12/23	1/31/25	1/31/25	1/31/25	2/4/22	1/31/25

Clinic Site: Mason Co Health Dept / Other: _________________ Comments: ______________________

Signature & Title of Vaccine Administrator: __________________________________ Date: ___________