Teen Vaccine Request Form

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

Patient's Name: _____ Date of Birth: ____/____/_____ Patient's Age: _____

Parent/Guardian: _____ Primary doctor or healthcare provider: _____

1. Does the patient have any allergies to medications, foods, or latex?	☐ No ☐ Yes ☐ Don't Know If Yes: _____
2. Has the patient ever had a serious reaction to a vaccine in the past?	☐ No ☐ Yes ☐ Don't Know
3. Does the patient have any long-term health problems?	☐ No ☐ Yes ☐ Don't Know If Yes: _____
4. In the past 3 months, has the patient 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. Has the person to be vaccinated ever felt dizzy or faint before or after a shot?	☐ No ☐ Yes ☐ Don't Know
6. Is the person to be vaccinated pregnant?	☐ 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 the person named above for whom I am authorized to make this request.

Parent/Guardian Signature: _____ Date: _____

OFFICIAL USE ONLY

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

	MCV4	MEN B	PCV	POL	VAR	COVID
Mfgr.						
Lot #						
Dosage						
Site/Route						
VIS Given	1/31/25	1/31/25	5/29/25	1/31/25	1/31/25	1/31/25

Clinic site: Mason Co Health Dept / Other: _____ Comments: _____

Signature & Title of Vaccine Administrator: _____ Date: _____

Updated 3/26/26