# Pediatric Vaccine Request Form

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

Child's Name: _____ Date of Birth: ____/____/____ Parent/Guardian: _____

| | |
|---|---|
| 1. Does the child have any allergies to medications, foods, or latex? | ☐ No ☐ Yes ☐ Don't Know<br>If Yes: _____ |
| 2. Has the child ever had a serious reaction to a vaccine in the past? | ☐ No ☐ Yes ☐ Don't Know |
| 3. Does the child have any long-term health problems? | ☐ No ☐ Yes ☐ Don't Know<br>If Yes: _____ |
| 4. In the past 6 months, has the child 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; regularly taken aspirin or salicylate medication? | ☐ No ☐ Yes ☐ Don't Know |
| 5. Is the child anxious about getting a shot today? | ☐ 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 | POL | HBV | HIB | MMR | VAR |
|---|---|---|---|---|---|---|
| Mfgr. | | | | | | |
| Lot # | | | | | | |
| Dosage | | | | | | |
| Site/Route | | | | | | |
| VIS Given | 10/15/21 | 1/31/25 | 1/31/25 | 8/6/21 | 1/31/25 | 1/31/25 |

| | HAV | FLU | PCV | ROT | RSV | COVID |
|---|---|---|---|---|---|---|
| Mfgr. | | | | | | |
| Lot # | | | | | | |
| Dosage | | | | | | |
| Site/Route | | | | | | |
| VIS Given | 1/31/25 | 8/6/21 | 5/12/23 | 10/15/21 | 1/31/25 | 1/31/25 |

Multi-Vaccine VIS: ___ 7/24/23 ProQuad VIS: ___ 1/31/25

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

Signature & Title of Vaccine Administrator: _____ Date: _____