INFLUENZA VACCINE ADMINISTRATION RECORD
INFORMATION ABOUT PERSON TO RECEIVE VACCINE

(Please Print)

NAME: LAST_____ FIRST_____ MI_____

GENDER: ☐ MALE ☐ FEMALE BIRTHDATE_____ AGE_____

ADDRESS: STREET_____ CITY_____

STATE _____ ZIP_____ COUNTY_____ PHONE NUMBER _____

MEDICARE/MEDICAID #_____

ARE YOU DIABETIC? ☐**Yes** ☐**No** Doctor's Name_____

I have read or have had explained to me the information contained on the Vaccine Information Sheet about vaccine(s) that will be administered. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccines(s) checked on the reverse side be given to me or to the person named above for who I am authorized to make this request.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.
I have received a copy of Macoupin County Public Health Department's Notice of Privacy Practices today.

Signature of person to receive vaccine or person authorized to make request.

X_____ DATE_____

(Please do not fill below line office use only)

DATE ADMINISTERED: _____ ☐ VFC

INFLUENZA	PNEUMOCOCCAL
☐_____ Exp. Date: _____	☐_____ Exp.Date_____
SITE ADMINISTERED:	**SITE ADMINISTERED:**
☐ LUE _____ ☐ LLE _____	☐ LUE _____ ☐ LLE _____
☐ RUE _____ ☐ RLE_____	☐ RUE _____ ☐ RLE_____

ADMINISTERED BY:

( ) Mary Burns, RN ( ) Keri Loveless, RN ( ) Tracy Pocklington, RN ( ) _____

( ) Karen Hazzard, RN ( ) Edie Luddeke, RN ( ) Margie Thomae, RN ( ) _____

( ) Jennifer Byots, RN ( ) Rita Tranter, RN ( ) Shirley Young, RN ( ) _____

COMMENTS:_____

_____

If you live with diabetes, print, then complete this form and bring it with you to the Macoupin County Public Health Department's Seasonal Flu Vaccine Clinic.

If you do not have diabetes, skip this form. Thanks.

Macoupin County Public Health Department
RURAL DIABETES CONTROL PROGRAM SURVEY

Please print and complete the entire form.
Thank you for your help.

Name: _____ Date diagnosed with diabetes _____

Address _____ City _____ Zip _____

Race

☐ White ☐African American ☐ Hispanic ☐ Eskimo/Native American ☐ Other _____

Marital Status

☐ Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Number of years of education you have completed _____ Birthdate _____

Type of Diabetes

☐ Gestational ☐ Type I
☐ Type II ☐ Unspecified

What kind of treatment are you receiving for your diabetes?

☐ Insulin ☐ Nutritional Therapy ☐ Exercise
☐ Oral Medication ☐ Insulin Pump ☐ None
☐ Glucose Monitoring

How many times in the past twelve months have you been seen by a health care professional? Doctor, Nurse Practitioner, or Physician's Assistant _____ Current Height _____ Current Weight _____

How many times in the past twelve months have you received diabetes education? _____ Would you like to receive additional education? ☐Yes ☐No

What areas of diabetes would you like to learn more about? ☐ What is diabetes ☐ Medication
☐ Nutrition ☐ Exercise ☐ Stress ☐ Sick Days ☐ High/Low Blood Sugars ☐ Blood Testing
☐ Complications ☐ Insulin Pumps ☐ Other _____

How many times in the past twelve months have you received nutrition education? _____ Are you interested in speaking with a dietician?

Were you hospitalized for any reason in the past twelve months? ☐Yes ☐No How many times for a diabetes related diagnosis? _____ ☐Yes ☐No

How many times a day do you check your blood glucose? _____

Don't forget to complete the second page of this form.

Have you heard of the Hemoglobin A1c (or glycosylated hemoglobin)? ☐Yes ☐No

How many times have you had a Hemoglobin A1c in the past twelve months? _____
When and what was the result of your last Hemoglobin A1c? Date: _____ Result: _____

Have you ever been diagnosed with high blood pressure? ☐Yes ☐No Receiving treatment? ☐Yes ☐No

Have you had a lipid profile (cholesterol test) in the last year? ☐Yes ☐No

Have you ever been diagnosed with high cholesterol? ☐Yes ☐No Are you receiving treatment? ☐Yes ☐No

When was your last eye exam (when drops were put into your eyes to dilate them)? _____

How many times in the past twelve months have your feet been examined by a health care professional? _____

Have you had a flu shot in the past twelve months? ☐Yes ☐No

Has your doctor ever talked to you about taking aspirin on a daily basis? ☐Yes ☐No
Do you take aspirin on a daily basis? ☐Yes ☐No

Do you smoke? ☐Yes ☐No If yes, have you tried to quit? ☐Yes ☐No

If no, have you ever smoked and how long? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No Days per week you drink? _____ Drinks per day? _____

Thank you for helping us!

For questions contact Debbie Link
Diabetes Control & Prevention Program
805 N. Broad, Carlinville, IL 62626
217-854-3223, ext. 225

If you are diabetic, please print this consent form and bring to the seasonal flu clinic. The consent gives permission to enter your diabetes data into the computer system. If you have questions, please call Debbie Link at 217-854-3223, ext. 225.

CORNERSTONE INFORMED CONSENT FORM

Name of Participant:_____
(Last) (First) (M)

Date of Birth:_____ Male _____ Female _____
(Month) (Day) (Year)

Participant's ID Number_____

It is important that you read the following. If there is anything that you do not understand or if you have any questions, be sure to ASK.

Welcome to Cornerstone, a system that collects data on a wide range of health care services to individuals. These services include WIC (Women, Infants and Children); Immunizations; Case Management; Prenatal and Postpartum Care; Pediatric Primary Care; Early Intervention; Breast and Cervical Cancer; Diabetes Control; and Healthy Families Illinois.

We are asking for permission to collect information about the participant and store it in a centralized computer system maintained by the Illinois Departments of Human Services and Public Health. Based on the information collected during the enrollment or registration process, we will determine whether you need further service. Only those authorized health care professionals with a direct need to know about you will have access to this information. Information may be released for service authorization, audit, and evaluation purposes. Necessary information, without any client's name, will be sent to federal agencies that fund these programs.

By signing this consent form, you agree to allow certain information to be collected by this agency/clinic. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private, and not release it to anyone else without your written permission unless the law allows it.

A. I authorize Macoupin Cty Public Health (Cornerstone site) to collect information during the enrollment/registration process.

B. This authorization covers all the medical, social and financial information about the participant, including: participant background and demographic information; health visit information; medical and developmental history; prenatal, birth, and postpartum data; infant/child visit data; immunization records; participant risks; problems or factors that prevent the participant from receiving proper medical care; appointments made and services received; goals and care plan; WIC food packages; program information; information required by the federal Maternal and Child Health Block Grant Program, and Early Intervention. Any information you do not want released should be written in Part D.

C. This authorization also covers information about mental health, AIDS, HIV, sexually transmissible diseases, alcoholism, and drug use which may be reported by me. I understand that I am not required to report or discuss those matters with anybody.

D. The following information I do NOT want to be shared:

E. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done before I revoked it. I also understand and agree not to hold the Illinois Departments of Human Services and Public Health liable for the release of any information about me in accordance with the terms of this consent form.

F. A photostatic copy/facsimile of this consent will be as valid as the original

For child participant:

_____
Signature of parent/legal guardian/caretaker/Date

OR X

For adult participant:

_____
Signature of adult participant/Date

Signature of Witness:_____ Date:

Revised July 2001