

Please Print Clearly

Harrison County Health Department / Harrison County Hospital Flu Vaccine Clinic

October 4, 2011

Name: _____ Phone: _____

Address: _____

City/State/Zip: _____

Birth date: _____ Gender: M F

Method of Payment: Cash _____ Check _____ Medicare #: _____

Of my own free will I consent to receive an influenza vaccine (flu shot). I understand that no guarantees are made as to the effect of this immunization given to me. I have received a Vaccine Information Statement (VIS) dated 7/26/11 to read.

Signature

Date

- | | *YES | NO |
|---|--------------------------|--------------------------|
| Do you have a fever of 100.4° or higher? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a severe allergy to chicken eggs? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a severe reaction to a flu shot in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had Guillain-Barre syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any other medical questions? | <input type="checkbox"/> | <input type="checkbox"/> |

*** any yes answers, send to special needs**

Influenza vaccine, 0.5 ml, IM
Site (circle one) RA LA

Nurse initials: _____