

Please Print Clearly

Harrison County Health Department / Hospital Flu Vaccine Clinic

Name: _____ Ph: _____

Address: _____

City/State/Zip: _____ Birthdate: _____ Gender: **M** **F**

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

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 dated to read.

Signature: _____ Date: _____

***Yes No**

- Do you have a fever of 100.4 or higher?
- Do you have a severe allergy to chicken eggs?
- Have you had a severe reaction to a flu shot in the past?
- Have you ever had Guillain-Barre syndrome?
- Do you have any other medical questions?

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

<p>Influenza Vaccine, 0.5 ml, IM Site: (circle one) RA LA Nurse initials: _____</p>
--