

**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 current Vaccine Information Statement 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</p> <p>Nurse initials: _____</p>
---