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: _____

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	*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

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

Nurse initials:_____