

Henry County Health Center REQUEST FOR INFLUENZA VACCINE

I have received a copy of *Influenza Vaccine, What you need to know, 2011/2012* I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request. By signing this form I also give permission to release any and all medical information to other organizations to adjudicate any medical claim or billing related to this immunization.

I have the following health condition:

heart condition diabetes asthma other lung disease
 high blood pressure

ANSWER THESE QUESTIONS BEFORE GETTING YOUR SHOT!! IF YOU ANSWER YES TO ANY OF THESE, TELL THE STAFF AND CONSULT WITH YOUR DOCTOR BEFORE GETTING YOUR SHOT!!

1. Are you allergic to eggs?
2. Have you ever had a serious allergic reaction to a dose of influenza vaccine?
3. Are you ill today?
4. Do you have a history of Guillain-Barre Syndrome (GBS)?
5. Are you pregnant?

PLEASE PRINT

LAST Name	First Name	Middle Name
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Birth Date	Age	MEDICARE Number	MoHealthnet Number
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Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Do have any other insurance? Yes No If yes please list: _____

(Voluntary information) Ethnic Origin: <input type="checkbox"/> white <input type="checkbox"/> African American <input type="checkbox"/> other <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native	Gender: <input type="checkbox"/> female <input type="checkbox"/> male
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Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner <input type="checkbox"/> Unknown	Employment Related: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Signature of person to receive vaccine or person authorized to make the request _____ Date _____
X

For Clinic Use Only -- Do Not Write Below This Line

Clinic: _____ Date: _____

Signature of person administering Vaccine: _____

Site: Deltoid Left Right Other _____

Manufacturer/Lot Number	Sanofi Pasteur Fluzone #UH453AC	Expires 6-30-12
Manufacturer/Lot Number	Sanofi Pasteur Fluzone #UT427AA	Expires 6-30-12
Manufacturer/Lot Number	Sanofi Pasteur High Dose #UH459AC	Expires 4-23-12



