For Office Use Only		
Rm ______ Checkout? □ Yes □ No	~~□ IN~~ ~~□ OUT~~ ✓ **PVP** ~~□ W/C~~	**Patient is:** □ **New Pt** □ **F/U** □ **Est Pt**

Influenza Vaccine Paperwork

For MA Use Only

Hx of Asthma Y____N_		Hx of Bronchitis Y______N_	
Height	________	Weight	________
Temp	________	Pulse	________
BP	_____/____	LMP	________
Resp	________	Pul Ox	________

DEMOGRAPHIC INFORMATION

Name ______________________________________ ______________________________________
Last *First* *MI* *Address*

DOB ______/______/_______ SSN ______-_____-_________ ______________________________________
City *State* *Zip*

Age _________ Sex: □ M □ F Emergency Contact____________________________ ________________
Name *Phone*

Home Phone (_____) ______________________________ Alternate Phone (_____) ______________________________
□ Yes, *messages can be left at this number.* □ Yes, *messages can be left at this number.*

FLU VACCINE QUESTIONNAIRE

1.	Vaccine Information Statement received (on clipboard)?:	Yes	No
2.	Currently experiencing any moderate or severe illness?	Yes	No
3.	Allergy to eggs/poultry?	Yes	No
4.	Allergy to the preservative thimerosal?	Yes	No
5.	Allergy to latex?	Yes	No
6.	Received flu vaccine in past?	Yes	No
	If yes, approximate year of last dose: _____________		
7.	Any previous reaction/problem with flu vaccines:	Yes	No
	If yes, approximate date of last dose: _____________		
8.	Ever had Guillain Barre Syndrome:	Yes	No
9.	Currently taking: cortisone, prednisone, other steroid,		
	x-ray treatments, warfarin, anticoagulant, or theophylline:	Yes	No

TREATMENT CONSENT AND AUTHORIZATION

I have read or have had explained to me the information in the “Vaccine Information Statement” regarding the risk and benefits associated with the influenza vaccination. I understand the benefits and risks of the vaccine recommended. I authorize Urgent and Family Care at Avery Ranch, and its healthcare providers to render necessary treatment. I acknowledge and agree to comply with Urgent and Family Care Financial and General Policies.

____ ______________________
Patient/Guardian Signature Date

Vaccine // Manufacturer: Novartis **Lot #**: 1101101 **Dose**: 0.5ml IM

Site (circle one): Left Deltoid Right Deltoid

MA Signature ______________________________ Date ________________________

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