

**For Office Use Only**



**For MA Use Only**

Rm \_\_\_\_\_  
 Checkout?  IN  OUT  
 Yes  PVP  
 No  W/C

Patient is:  
 New Pt  
 F/U  
 Est Pt

Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Temp \_\_\_\_\_ Pulse \_\_\_\_\_  
 BP \_\_\_\_\_ / \_\_\_\_\_ LMP \_\_\_\_\_  
 Resp \_\_\_\_\_ Pul Ox \_\_\_\_\_

**Influenza Vaccine Paperwork**

**DEMOGRAPHIC INFORMATION**

Name \_\_\_\_\_  
Last First MI Address

DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
City State Zip

Age \_\_\_\_\_ Sex:  M  F Email: \_\_\_\_\_ @ \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_\_  
 Yes, messages can be left at this number.  Yes, messages can be left at this number.

Emergency Contact \_\_\_\_\_  
Name Phone Relationship

**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,<br>x-ray treatments, warfarin, anticoagulant, or theophylline: | Yes | No |
| 10. | Is the patient 18 years of age?  | 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 believe 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 General Office, Financial and Privacy Policies, and acknowledge their compliance with HIPAA.

\_\_\_\_\_  
 Patient/Guardian Signature

\_\_\_\_\_  
 Date

**Vaccine // Manufacturer:** Flulaval // GlaxoSmithKline **Lot #:** AFLLA581AA **Dose:** 0.5ml IM

**Site (circle one):** Left Deltoid Right Deltoid

\_\_\_\_\_  
 MA Signature

\_\_\_\_\_  
 Date

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