Please Print Clearly

Harrison County Health Department / Harrison County Hospital Flu Vaccine Clinic

Name:_____ Phone:_____

Street 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:_____, 20____

	***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:_____