FLU FORM (2016) **IN: _________OUT: ___________**

STAFF ONLY:
Medicare Part B number as written on Medicare Card:_______________________________

Private Pay _________ Cash Amount: _______ Check Amount: _______Check # _________

VFC Eligible: Y ____ No ___ Suggested Donation Amt Received: _________Check # ____

Please X One of the blanks for VFC: No Ins. ___Medicaid ___ Underinsured____
American Indian/Alaskan Native ____ If Medicaid please indicate what type of MCO & #
****

I have read or have had explained to me the information on this form about influenza and influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

PLEASE PRINT

LAST NAME: ________________________ FIRST NAME: ____________________

ADDRESS: ______________________________________ Male ____ Female____

CITY: _______________________STATE: __________ ZIP CODE _____________CO___

TELEPHONE: _______________________ PHYSICIAN: _________________________

BIRTHDATE: ______________________ Example (01-01-1901) AGE: _______

Are you allergic to eggs, chicken, or chicken feathers? **Yes ___ No ___**

Have you had a fever during the last 24 hours? **Yes ___ No ___**

Are you pregnant? **Yes ___ No ___ N/A ____**

Have you ever had a flu shot? **Yes ____No ___**

Have you ever had a reaction to a flu shot? **Yes ___ No ___**

Were you ever paralyzed by Guillain-Barre Syndrome? **Yes ____No ___**

If administering vaccine to your child, does child have asthma (or wheeze)? **Yes ____No ___ N/A ___**

Signature of person to receive vaccine or person authorized to make the request. I do hereby acknowledge privately offered receipt of a copy of the Notice of Privacy Practice, Policy and Procedure. A notice will be sent to your physician informing him that our agency has given you a flu shot.

Signature: _________________________________ Date: _______________

FOR NURSES USE ONLY

DATE VACCINATED: ________________________________

SITE: RD/LD **Route ________** **EXPIRATION DATE: ________________**

MANUFACTURE & LOT NUMBER: **_______________________________**

ADMINISTERED BY: _____________________COMMENTS________________________