Date: _____ Patients date of birth: _____

Patients name: _____ _____

Last Name First name

If the patient has been exposed to someone in the last 14 days that tested positive for COVID-19, please schedule your appointment outside of this window.

To allow for social distancing please arrive at your scheduled appointment time!!

Is the patient at least 6 months of age? _____

Is the patient currently ill or had a fever within the last 48 hours? _____

Has the patient had any adverse reactions to vaccines? _____

Has the patient had Guillain-Syndrome? _____

Is the patient allergic to eggs? _____

"I have read or have had explained to me information about the indicated vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask the indicated vaccine be given to me or the named person whom I am authorized to make the request."

Office use only: Patients temperature: _____

Vaccine lot/exp	Site given:	Signature of vaccine admin:	Signature of **Parent**/Patient:
	LA RA	_____	_____
	LL RL		

FLU CLINIC - SEASONAL INFLUENZA VACCINE 2020/2021 – INJECTABLE – 0.5ml