

Today's Date: _____ Last Name: _____ First Name: _____

SCREENING QUESTIONS - Please circle Y or N for Yes or No. Use the back for allergy and other information						
	#1 Self	Family Member #2	Family Member #3	Family Member #4	Family Member #5	Family Member #6
First and Last Name						
Date of Birth						
Relationship to above						
Primary Physician/Nurse Practitioner						
First time receiving the flu vaccine? <small>*It is recommended that children 8 and under who have NEVER had flu vaccine or had only one dose, receive two dose in the same flu season.</small>	Y N	Y N	Y N	Y N	Y N	Y N
Allergies to chicken eggs, egg products, thimerosal, latex or any component of the flu vaccine?	Y N	Y N	Y N	Y N	Y N	Y N
Have you/your child ever had a severe allergic reaction to previous flu vaccine?	Y N	Y N	Y N	Y N	Y N	Y N
Do you have a history of Guillain-Barre Syndrome (GBS)?	Y N	Y N	Y N	Y N	Y N	Y N
Have you received any vaccines in the past 30 days? If yes, list vaccines and dates in the box.	Y N	Y N	Y N	Y N	Y N	Y N

Address: _____ P. O. Box: _____
 City: _____ State: _____ Zip Code: _____
 Primary Phone: _____ - _____ - _____ Alternate Phone (Optional): _____ - _____ - _____

CONSENT

CONSENT - I have read or had explained to me the information in the Vaccine Information Statement about the 2019-2020 influenza vaccine (08/07/2015). I believe I understand the benefits and the risks of the influenza vaccine and ask that the vaccine be given to me and/or my child/children. I understand that these vaccines will be entered into the Iowa Immunization Registry (IRIS). I attest I am the child's/children's parent/legal guardian and may provide consent for the immunizations. My signature on the back indicates my consent for me and/or my child/children to receive these vaccines.

Turn page over to complete

