

Sutter County Public Health - Seasonal Influenza 2019-2020

Name of person to receive vaccine (PRINT LEGIBLY BELOW):

Last: _____ First: _____ Ethnicity/Race: _____

Address: _____
Number Street Apt.# City Zip code

Male Female Telephone # _____ Birthdate: _____ Age: _____

I have read or had explained to me the "Influenza Vaccine Information Statement, 8/15/2019". I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and request that it be given to me or the person for whom I am authorized to make this request. ONLY injectable influenza vaccine will be administered.

Please answer all questions (about person receiving the vaccine)	Yes	No
1. Are you sick today?		
2. Do you have allergies to latex, a vaccine component, or severe egg allergy?		
3. Have you ever had a serious reaction after receiving a Flu Vaccine in the past?		
4. Have you ever had Guillain-Barré syndrome?		
5. Females: is there a chance that you could be pregnant?		
After vaccination, we suggest you wait on-site for 15 minutes to make sure you do not have an adverse reaction to the vaccine.		

Sign below if 18 or older. If person to receive vaccine is under 18, parent or legal guardian please sign below:

(Sign here)X _____ Date _____

Staff Use Only! VFC State Registry Consent Signed Registry #: _____

Services provided by: _____ / _____
Nurse assessing patient's needs (signature) / Nurse administering vaccination (signature)

Site (Circle)	Vaccine	Manufacturer	Lot#	VIS date	Fee Received
RD LD RL LL				8 -15-2019	

(Circle)
Vaccine type/dose administered: .5 DOSE .5 DOSE (P-free)