

FRANKLIN COUNTY HEALTH DEPARTMENT
1418 S MAIN, SUITE 1 OTTAWA, KANSAS 66067
785-229-3530

NAME: _____ DATE OF BIRTH: _____ AGE: _____

PHONE: _____ SEX: Male _____ Female _____ Marital status M S W

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

Name as it appears on Medicare/Medicaid Card _____

Medicare/Medicaid Number _____ Doctor's Name _____

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child injectable influenza vaccination today. If you answer "yes" to any question, it does not mean your (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain.

- | | | | |
|--|------------|-----------|-------------------|
| 1. Is the person to be vaccinated sick today? | Yes | No | Don't know |
| 2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? | Yes | No | Don't know |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | Yes | No | Don't know |

INFLUENZA (FLU) VACCINE ADMINISTRATION RECORD

The doctor or clinic may keep this record in you medical file or your child's medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that manufactured the vaccine, the vaccine's special lot number, the signature and title of the person who gave the vaccine and the site where the vaccine was given.

I have been given a copy and have read, or have had explained to me, the information in the "Vaccine Information Statement" (VIS) regarding the influenza vaccine. **YES** _____ **NO** _____

Signature of person to receive the vaccine or person authorized to make the request (parent or guardian): I believe I understand the benefits and risks of the Influenza (FLU) vaccine and ask that the vaccine be given to me or to the person named for whom I am authorized to make this request.

Signature of Client _____ Date _____

FOR OFFICE USE ONLY

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Clinic Site 030 Date of Injection _____ Injection site _____

Manufacturer: Sanofi Pasteur Lot # U3186AA ExpDate: 06-30-2010

Signature of Nurse _____

