

**KITTITAS COUNTY PUBLIC HEALTH DEPARTMENT**  
2016-17 Drive Thru Clinic Influenza Vaccination

Name: (Last)	(First)	(Middle Initial)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Age:
Mailing Address:	City:	Zip:	Home Phone:	Birth date:

Please provide your Medicare number below:

Medicare \_\_\_\_\_

*Please answer the following questions for the person receiving the vaccine.*

	YES	NO	UNSURE
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have a severe allergy to eggs or to a vaccine component?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a severe reaction, including Guillain-Barre Syndrome, after receiving a flu vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. For children, have <i>fewer than four weeks</i> passed since your child's last flu shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. <input type="checkbox"/> Check this box if this is your child's first flu shot in his or her life.			

How did you hear about this clinic?  Newspaper  Radio  Flyer  Provider  Friend/Family  Other: \_\_\_\_\_

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

➔ I have received the Notice of Privacy Practices and consent to the disclosure of this protected health care information for treatment, payment and health care operations.

I am  the patient  the child's Parent/Guardian (please print name) \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Reviewer Notes:**

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	Manufac.	Lot #	Dose	Site	Route	Signature of Administrator
<input type="checkbox"/> Free Adult Flu MDV (Z23)	Seqirus	1619401	0.5cc	Left	IM	
<input type="checkbox"/> Adult Flu PFS (Z23)	Seqirus	168803	0.5cc			
<input type="checkbox"/> Infant Flu (Z23) Fluzone	Sanofi	UT5594LA	0.25cc	Right		
<input type="checkbox"/> Child Flu MDV (Z23)	GSK	E97K2	0.5cc			Co-Signer

Paid \$ \_\_\_\_\_  Cash  Check # \_\_\_\_\_ Receipt # \_\_\_\_\_