Kittitas County Public Health Department

KITTITAS COUNTY PUBLIC HEALTH DEPARTMENT
2017 Drive Thru Clinic Influenza Vaccination

Name: (Last) (First) (Middle Initial)			Sex: □ M □ F □ 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?	☐	☐	☐
2. Does the person to be vaccinated have a severe allergy to eggs or to a vaccine component?	☐	☐	☐
3. Has the person to be vaccinated ever had a severe reaction, including Guillain-Barre Syndrome, after receiving a flu vaccine in the past?	☐	☐	☐
4. For children, have ***fewer than four weeks*** passed since your child's last flu shot? 5. ☐ 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:

	Manufac.	Lot #	Dose	Site	Route	Signature of Administrator
□ **Free** Adult Flu MDV (Z23)	Seqirus	1619401	**0.5cc**	**Left**	**IM**	
□ Adult Flu PFS (Z23)	Seqirus	168803	**0.5cc**			
□ Infant Flu (Z23) Fluzone	Sanofi	UT5594LA	**0.25cc**	**Right**		
□ Child Flu MDV (Z23)	GSK	E97K2	**0.5cc**			Co-Signer

Paid $_____ ☐ Cash ☐ Check # _____ Receipt # _____