



Urgent Care Center

Flu Vaccine Registration

Name (Last, First, MI): _____ D.O.B. ____ / ____ / ____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____

- 1. Have you ever had flu vaccination before? Yes or No
- 2. Have you ever had any serious reaction to the flu vaccine? Yes or No
- 3. Are you allergic to eggs? Yes or No
- 4. Do you currently have a fever or feel ill? Yes or No
- 5. Are you currently receiving chemotherapy for cancer? Yes or No
- 6. Are you currently taking any of the following medications: Yes or No
 Coumadin: _____
 Cortisone or Steroids (Prednisone or Medrol): _____
 Theophylline (Theodure, Primatene Tabs, Slobid): _____
- 7. Have you ever had Guillen-Barre Syndrome? Yes or No
- 8. Are you allergic to Latex? Yes or No
- 9. If you are female, are you pregnant? # Weeks _____ Yes or No

I received or was offered a copy of the Influenza Vaccine Information Statement (VIS). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I agree that Rapid-Med Urgent Care Center shall have no responsibility or liability if I contract influenza, other respiratory diseases, or suffer any other adverse reaction following administration of the flu shot. I acknowledge that I have read or was offered a copy of the HIPAA Policy for Rapid Med Urgent Care.

X Signature of Responsible Person: _____ Date: _____
(Parent/Guardian's Signature if a minor)

Office Use Only:

MANUFACTURER AND LOT#: Sanofi Pasteur Lot:		Exp: 6-30-2011	CDC Interim VIS 8/10/10
SITE OF INJECTION:	Right / Left	Deltoid / Thigh	Temperature:
Name and Title of Vaccine Administrator:			
Payment Received by:		Payment Amount:	
Method of Payment: <input type="checkbox"/> Cash <input type="checkbox"/> Check Check No. _____ <input type="checkbox"/> Credit Card Credit Card Inv. # _____			