SIERRA COUNTY HEALTH DEPARTMENT
Seasonal Flu Shot Drive-Thru Clinic

PRINT NAME: ____________________

BIRTH DATE: ____________________ AGE: ____________

MAILING ADDRESS:____________________ZIPCODE:____________

PHYSICAL ADDRESS:____________________

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs, Neomycin or Thimerosal which is so bad that it needs medical treatment?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barre' syndrome?	☐	☐	☐
5. Is the person receiving the shot pregnant or will be pregnant during the flu season?	☐	☐	☐

- I have read or had explained to me the "Influenza Vaccine Information Statement". 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 to the person for whom I am authorized to make this request. I authorize my/my child's Immunizations to be input in the California Immunization Registry.

____________________ ____________________

Signature Date