



Public Health
Prevent. Promote. Protect.

Osage County Health Department
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OSAGE COUNTY HEALTH DEPARTMENT
2010-2011
INFLUENZA CONSENT FORM
PATIENT MUST BE 6 MONTHS OR OLDER TO RECEIVE SERVICES

LAST NAME _____ FIRST NAME _____ MI _____

STREET ADDRESS/P.O BOX _____ City _____

STATE _____ ZIP _____ MALE OR FEMALE _____

DATE OF BIRTH _____ AGE _____ PHONE# _____

Please answer the following questions and information below

Have you ever had a flu shot before? ----- yes _____ no _____

Do you have a cold, fever, or acute illness? ----- yes _____ no _____

Are you allergic to chicken eggs or egg products? ----- yes _____ no _____

Have you ever had an allergic reaction to the flu vaccine -----yes _____ no _____

Have you ever had Guillain-Barre Syndrome (GBS) ----- yes _____ no _____

I hereby certify that the foregoing history is true and complete to the best of my knowledge and request the influenza vaccine. I have been offered a copy of the Vaccine information statement.

Patient Signature _____ Date _____

THIS SECTION IS FOR CLINIC PERSONAL USE ONLY

Medicare # _____ Medicaid# _____

BCBS Card Name _____ ID# _____ Group# _____

Cash _____ Check# _____ Bill Employer _____

Manufacturer: Novartis

Lot # 111821P1

Vaccine Exp Date 5/31/2011

Nurses Signature: _____

Registration

Time In _____

Time Out _____

Vaccination

Time In _____

Time Out _____