Public Health
Prevent. Promote. Protect.

Osage County Health Department
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Lyndon, Kansas 66451

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OSAGE COUNTY HEALTH DEPARMENT
2013-2014
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.

Parent /Patient Signature_____ Date_____

THIS SECTION IS FOR CLINIC PERSONAL USE ONLY

Medicare #_____ Medicaid#_____
BCBS Card Name_____ ID#_____ Group#_____
Cash _____ Check#_____ Bill Employer_____

Manufacturer Sanofi-Pasteur Vaccines
Lot
Vaccine Exp Date 6-30-2014

Nurses Signature: _____