466-7823

Are you running a fever today? Yes ____ No ____

Are you allergic to eggs? Yes ____ No ____

Have you ever had an allergic reaction to a flu shot? Yes ____ No ____

Who is your primary care Physician? ________________________________

I have read the information and have had an opportunity to ask any questions. I understand the benefits and risks of receiving the flu vaccination as described. I request the vaccine be given to me or the person named below for whom I am authorized to sign in behalf of.

Print Name ______________________Date of Birth _____________ Phone _____________________

Signature of Person Receiving Vaccine

_________________________________ Date ___________

(For pharmacy use)

Left Deltoid ____ *Right Deltoid* ____

Given by: ______________________________

Billing Type: Medicare ____ *Medicaid* ____ *Private Insur.* ____ *Cash* ____