Ledge Light Health District
DRIVE-THRU TO BEAT THE FLU
Seasonal Influenza Vaccine Administration Record (2019)

Please Print:

Last Name_____ **First Name**_____ **M.I.**_____

Address:_____
Street **Town** **State** **Zip Code**

Phone_____ **Date of Birth**_____ **Age**____ **Sex:** ☐ **Male** ☐ **Female**

Have you ever had a flu shot before? Yes___ No___

How did you hear about this clinic?_____

If you want us to notify you of flu clinics next year, please share your email:

_____

Please Answer The Following Questions:

Yes	☐ No	Are you sick or have a fever?
☐ Yes	☐ No	Have you ever had a serious reaction to a flu shot?
☐ Yes	☐ No	Any allergies to eggs (severe), gelatin, thimerosal (a preservative), gentamicin or arginine?
☐ Yes	No	Have you ever had Guillian-Barré Syndrome?

I have read or had explained to me the information sheet (VIS 8/15/19) about seasonal influenza and the influenza vaccine. I have had a chance to ask questions and I understand the benefits and risks of the influenza vaccine. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

For participants who are minors (less than 18 years of age): I attest that I am the legal guardian of this minor and I have authority to provide consent for this vaccination.

Signature_____ ***Print Name***_____ ***Date*** _____

For Clinic Use:
Dose: ☒ 0.5 ml injectable Vaccine Manufacturer & Lot #:

Site: ☐ RD ☐ LD Administered by: Date: