Please Circle: Cash Check# Credit Card

PLEASE PRINT CLEARLY

____

Last Name First Name Date of Birth Age M or F

____

Address City State Zip Code

____

Home Phone Cell Phone Email Address

____

Please answer the following:

Do you have a fever today or are you ill?	Yes	No
Have you ever had a flu shot?	Yes	No
Have you ever had Guillain-Barre syndrome?	Yes	No
Have you ever had an allergic reaction to eggs?	Yes	No

Consent and Release:

The above information is correct and I have read or received a copy of the Vaccine Information Statement for this vaccine. I understand the benefits and the risks of the influenza vaccine and request that the vaccine be given to me or the person named above for whom I am authorized to make this decision. I have had the chance to ask questions, which were answered to my satisfaction.

Signature:____ **Date:**______________________________
(Parent or Guardian of Minor please sign)

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For Clinic Use Only

Influenza Manufacturer/LOT Exp. Date Site Route Dose MA