TEXAS MEDCLINIC

Flu Vaccine QUESTIONNAIRE / AUTHORIZATION

PATIENT NAME: **AGE:**

DATE OF BIRTH: (MM/DD/YYYY) SEX: M F

PHONE:

STREET ADDRESS:

CITY / ZIP:

SOCIAL SECURITY #:

MEDICARE ID#:

	YES	NO
a) If you are eligible for Medicare, are you currently enrolled in a replacement insurance plan? (i.e. Humana Gold, Secure Horizons, other?)		
b) If you are over 65 years of age, do you want the High Dose Influenza Vaccine?		
c) Have you been sick with fever greater than 100.5℉ in the past 48 hours?		
d) Have you had a severe reaction to eggs, egg products, chicken, or chicken products?		
e) Have you previously had an adverse reaction to a flu shot?		
f) Are you allergic to latex?		
g) Are you allergic to thimerosal (a preservative in the vaccine)?		
h) Do you have a history of Guillain-Barre Syndrome (GBS)?		
i) Do you have a history of blood clotting problems that prevent you from receiving injections?		

Patients on radiation therapy, chemotherapy or high dose steroids may not have a sufficient immune response to prevent influenza following vaccination. However, due to their high risk, they should still be vaccinated.

I hereby authorize the staff of *Texas MedClinic* to give me the 2011 Influenza Vaccine. I agree to release *Texas MedClinic,* its physicians and employees (and my current employer, their subsidiaries, divisions, affiliates, officers, directors and employees, or sponsoring agency, if applicable) from any and all liability for any adverse reaction (including anaphylactic shock or death) that may occur as a result of my receiving the Influenza Vaccine. I have been provided the Vaccine Information Sheet (VIS), which informs me of potential adverse reactions, and I have read and answered the above questions correctly, to the best of my knowledge.

Please select preferred wait time:

☐ ***I agree to WAIT near the flu shot location for 20 minutes after receiving the vaccine.***

☐ *I have received all the information regarding allergic reactions, both local and systemic, that can be anticipated following an injection of any kind and elect not to wait the 20 minutes as required by Texas MedClinic.*

PATIENT SIGNATURE: _____ DATE: _____

FOR STAFF USE ONLY

VIS Date: 7/26/11

Place Vaccine Sticker Here

Tech:_____

Payment: _____

Allergies: _____ **Site:** _____ **Time:** _____ **CA CK MC**