

TEXAS MEDCLINIC

FLU VACCINATION QUESTIONNAIRE / AUTHORIZATION

PATIENT NAME: _____
First Name Last Name

DATE OF BIRTH: _____ AGE: _____
Month (MM) Day (DD) Year (YYYY) Years

PHONE: (____) _____ SEX: M F
Area Code Phone Number Circle One

STREET ADDRESS: _____

CITY / ZIP: _____
City Zip Code

SOCIAL SECURITY NUMBER: _____
 MEDICARE ID#: _____

	YES	NO
a) If you are eligible for MEDICARE , are you currently enrolled in either HUMANA or Secure Horizons ? If so, please provide information and advise receptionist. _____	<input type="checkbox"/>	<input type="checkbox"/>
b) Have you been sick with fever greater than 100.5°F in the past 48 hours? _____	<input type="checkbox"/>	<input type="checkbox"/>
c) Have you ever had a severe reaction to eggs, egg products, chicken, or chicken products? _____	<input type="checkbox"/>	<input type="checkbox"/>
d) Have you previously had an adverse reaction to a flu vaccine? _____	<input type="checkbox"/>	<input type="checkbox"/>
e) Are you allergic to thimerosal (a preservative in the FLULAVAL vaccine)? _____	<input type="checkbox"/>	<input type="checkbox"/>
f) Do you have a history of Guillain-Barre Syndrome (GBS)? _____	<input type="checkbox"/>	<input type="checkbox"/>
g) Do you have a history of blood clotting problems that prevent you from receiving injections? _____	<input type="checkbox"/>	<input type="checkbox"/>

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 *TexasMedClinic* to give me the 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.

♦ I agree to WAIT near the flu vaccination location for 15 minutes after receiving the flu vaccination. ♦

PATIENT SIGNATURE: _____ DATE: _____

FOR STAFF USE ONLY

Place Vaccine Sticker Here

Payment: _____ CA CK MC

VIS Date: 08/11/09

Allergies: _____

Temp: _____ Site: _____ Time: _____ Tech: _____