



FLU Vaccine Registration and Questionnaire

Date: _____

Name: _____ Soc.Sec. #: _____
Last Name First Name MI

Address: _____

City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birthdate: _____

Emergency Contact: _____ Phone: _____

Have you ever had a reaction to the influenza vaccine?	Yes _____ No _____
Are you allergic to eggs or thimerosal?	Yes _____ No _____
Have you had cold or flu-like symptoms in the past few days?	Yes _____ No _____
Do you have a history of Guillain-Barre syndrome?	Yes _____ No _____
Do you have asthma, heart disease or diabetes?	Yes _____ No _____
Are you Pregnant?	Yes _____ No _____

If not an established patient at BCFH, please fill in the following:

My Medications: _____

My Allergies: _____

My regular Physician: _____

I understand that there can be adverse effects and request that Bozeman Creek Family Health administer an influenza vaccine to me.

Signature: _____

Date: _____

Office Use Only:

FluZone (_____) 0.25 cc _____ 0.5 cc _____

given R _____ L _____ deltoid _____ outer thigh _____

Lot #: _____ Expiration: _____

FluMist (Med Immune) 0.1 ml per nostril: _____

Lot #: 501090P Expiration: 11/20/11

VIS given to patient (Possible side effects discussed) Yes _____ No _____

Administered by: _____