

SIERRA COUNTY HEALTH DEPARTMENT  
Seasonal Flu Shot Drive-Thru Clinic

PRINT NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ ZIPCODE: \_\_\_\_\_

PHYSICAL ADDRESS: \_\_\_\_\_

EMAIL: \_\_\_\_\_

- |  | <u>Yes</u>               | <u>No</u>                | <u>Don't Know</u>        |
|--|--------------------------|--------------------------|--------------------------|
| 1. Is the person to be vaccinated sick today?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the person to be vaccinated have an allergy to eggs, Neomycin or Thimerosal which is so bad that it needs medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the person to be vaccinated ever had Guillain-Barre' syndrome?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is the person receiving the shot pregnant or will be pregnant during the flu season?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

6. Where did you hear about the Flu Shot Clinic/Drive Thru?

Please circle one

Newspaper

County Website

Social Media

Post Office

Flyer - Where: \_\_\_\_\_

Other: \_\_\_\_\_

- I have read or had explained to me the "Influenza Vaccine Information Statement". I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and request that it be given to me or to the person for whom I am authorized to make this request. I authorize my/my child's Immunizations to be input in the California Immunization Registry.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date