Flu Immunization Registration/Release Form

(Please fill out information completely)

Registration Information

Last name	First Name	Middle Initial	Date of Birth	Age

Address	City/State	Zip

Gender: ☐ Female ☐ Male

Home Phone	Cell Phone

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other _____

Last 4 digits of Social Security Number

1. **Is the person being vaccinated sick today?** ☐ **Yes** ☐ **No**
2. **Does the person being vaccinated have an allergy to a component of the vaccine?** ☐ **Yes** ☐ **No**
3. **Has the person being vaccinated ever had a serious reaction to influenza vaccine in the past?** ☐ **Yes** ☐ **No**
4. **Has the person being vaccinated ever had Guillain-Barré syndrome?** ☐ **Yes** ☐ **No**

Insurance Information: ☐ **Medicare** **Insurance #**_____

Services Requested: ☒ ***Influenza (flu shot)***	**I have requested vaccination services** from the Florida Department of Health in Pinellas County as indicated above. I have received and understand information provided in the Vaccine Information Statements.

Signature: _____ Date: _____

OR

Name of Legal Representative: _____

Relationship to Client: _____

Signature of Legal Representative _____

OFFICE USE ONLY

Vaccine	Route/Site	Mfg./Lot #
☐ Influenza (Flu PF) ☐ High Dose Influenza (65Y+)	IM ☒ LDT ☐ RDT ☐	

Date Administered: _____ Nurse Signature: _____

Print Nurse Name: _____

☐ Walk In; Family Size: _____

☐ Drive Thru; # in the car _____

Check In Time: _____

Check Out Time: _____

Form Check/Triage: _____

Dispensing: _____

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