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**

Home Phone | **Cell Phone**

Gender: ☐ Female ☐ Male

- ☐ American Indian or Alaska
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian
- ☐ Hawaiian
- ☐ Japanese
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ Other Non-White
- ☐ Other Asian
- ☐ Unknown
- ☐ Samoan
- ☐ Vietnamese
- ☐ White

Last 4 digits of Social Security Number (optional)

1. **Is the person being vaccinated sick today? ☐ Yes ☐ No**
2. **Does the person being vaccinated have any other serious allergies? ☐ Yes ☐ No**
   If YES Please List: _____
3. **Has the person been vaccinated ever had a serious reaction to a vaccine in the past? ☐ Yes ☐ No**
4. **Has the person been vaccinated ever had Guillain-Barré syndrome? ☐ Yes ☐ No**

Services Requested: ☐ ***Flu*** ☐ ***Fluad (high dose)*** ☐ ***Hep A*** ☐ ***Hep B*** ☐ ***Heplisav-B (2dose)*** ☐ ***Other_____***

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.

Medicaid (Insurance Information): _____

Today's Date: _____

OR

Name of Legal Representative: _____

Relationship to Client: _____

OFFICE USE ONLY

Vaccine	Route/Site	Mfg./Lot #	Vaccine	Route/Site	Mfg./Lot #
Influenza ☐ 01 ☐ 17	IM ☐ LDT ☐ RDT ☐		Heplisav-B (2dose) ☐ 05 ☐ 09 ☐ 17	IM ☐ LDT ☐ RDT ☐	
Fluad (high dose) ☐ 05 ☐ 17	IM ☐ LDT ☐ RDT ☐		Other:_____ ☐ 01 ☐ 05 ☐ 09 ☐ 17	IM ☐ LDT ☐ RDT ☐	
Hep A ☐ 01 ☐ 17	IM ☐ LDT ☐ RDT ☐			IM ☐ LDT ☐ RDT ☐	
Hep B ☐ 05 ☐ 09 ☐ 17	IM ☐ LDT ☐ RDT ☐			IM ☐ LDT ☐ RDT ☐	

Please check the box of the administering nurse: (Please Print)

☐ Shelly Personette ☐ Fannie Vaughn ☐ Vonet Lassiter ☐ Vanell Williams ☐ _____