Your Care
your health

3818 SW 21st Street, Suite 100, Redmond, OR 97756 541-548-2899

2020-2021 INFLUENZA VACCINE (FLU SHOT)

Please circle Yes or No

1. Have you ever had an allergic reaction to flu vaccine? **Yes or No**
2. Do you have a history of Guillain-Barre Syndrome? (Illness associated with nerve damage and muscle weakness.) **Yes or No**
3. Have you ever fainted after an injection? **Yes or No**
4. Do you feel ill today or do you have a fever? **Yes or No**
5. If you are female, are you pregnant? # Weeks_____ **Yes or No**
6. Do you desire the high dose vaccination (usually 65+) **Yes or No**
7. Will this be your first flu vaccination? **Yes or No**

I hereby certify that the foregoing history is true and complete to the best of my knowledge and I have received and read the "Vaccine Information Statement" from the CDC, have had an opportunity to ask questions that were answered to my satisfaction, and do wish to receive the flu vaccination fully understanding the risks and the benefits. I hereby consent to the administration of the flu vaccine (flu shot), I agree to remain at the clinic for at least 10 minutes after the vaccination if it is the first time being vaccinated. Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees, Your Care, LLC and their employees, owners and representatives. I will communicate the information provided to me today about my vaccination to my primary care provider if I have one. *I authorize Your Care, LLC to bill my insurance or my employer if I qualify.*

PATIENT INFORMATION AND CONSENT

LAST NAME:	**FIRST NAME:**	**MI:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHONE:			
BIRTHDATE:	**AGE:**		
SIGNATURE:		**DATE:**	

FOR CLINIC USE ONLY

MANUFACTURER AND LOT#:

Flucelvax 4+ Years (Single Dose)	**Fluzone High Dose 65+**	**Fluad 65+**	**Afluria 6mo-35mo**
Lot #: _____	Lot #: _____	Lot #: _____	Lot #: _____
NDC: _____	NDC: _____	NDC: _____	NDC: _____
Expiration Date: _____	Expiration Date: _____	Expiration Date: _____	Expiration Date: _____

SITE OF INJECTION: **R / L** **DELTOID** **THIGH**

SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR:

PAYMENT
Cash $_____ Check $_____ Direct Bill $_____Insurance _____