

\*PAYMENT OPTION

☐ Bill employer

## 2021-2022 Flu Vaccine Registration Form

Clinic # Employer	/name of clinic					
PRINT IN INK ONLY. *REQUIRED INFORMATION FOR PATIENT RECEIVING VACCINE.						
*Last name	*First name					
Middle name	Preferred name					
*Address	*City					
*State *Zip *Phone ☐ Home ☐	Cell *Date of birth (MMDDYYYY) *Age					
*SSN - last 4 digits *Legal sex (M/F) What is your g	ender identity? (check one)					
☐ Female ☐ N	lale  Transgender female Transgender male					
□ Non-binary	☐ Two-spirit ☐ Genderqueer					
☐ Prefer not to	answer					
PARENT/GUARANTOR INFORMATION IF THE PAT	IENT IS UNDER 18 YEARS OF AGE					
☐ Same as the policy holder (complete Policy Holder info)						
Other: (complete information below)						
Full name	<u></u>					
Date of birth Legal Sex	<u> </u>					
Address						
Phone						
Relationship to patient						

PLEASE COMPLETE THE FOLLOWING QUESTIONS, CHECK "YES" OR "NO."  Attention: If you answer "yes" to any of the questions, further assessment will be needed by the nurse.					Υ	N	
1. Does the person to	o be vaccinat	ed have any a	allergies to medicati	ons, eggs, or a vaccine comp	onent?		Г
2. Has the person to	be vaccinate	d ever had a	serious reaction afte	er receiving a vaccine?			
3. Has the person to	be vaccinate	d had Guillan	-Barre Syndrome wi	thin 6 weeks of a flu vaccinati	on?		
4. Has the person to	be vaccinate	d already rec	eived the flu vaccine	for this flu season?			
5. Is the person to be	e vaccinated p	oresently ill wi	th a fever, sore thro	at, or cough?			
6. Is the person to be	e vaccinated 6	65 years or ol	der?				
Only answer quest	ions 7 – 16 i	f you are int	erested in receivi	ng the FluMist nasal spray	<b>.</b>		
7. Is the person to be	e vaccinated y	ounger than	2 years or 50 years	or older?			Г
				, cancer, organ or bone marro osoriasis, or reduced immune			
•		•		ts the immune system such a ituximab, Orencia, or Remica			
10. Is the person to be compromised?	oe vaccinated	in close cont	act with anyone who	ose immune system is severe	ly		
11. Has the person to	o be vaccinate	ed received a	ny vaccinations in th	ne past 4 weeks?			
12. Has the person to	o be vaccinat	ed received ir	nfluenza antiviral me	edications in the past 48 hours	?		L
13. Is the person to b	oe vaccinated	pregnant or	you could become p	regnant in the next month?			L
•			•	lem with heart disease, lung omia, or other blood disorder?	disease,		
15. Is the child between	een 2 and 4 y	and 4 years of age, and has been told they have wheezing or asthma?					
16. If under 18 years	, does the pe	rson to be va	ccinated receive asp	oirin therapy or aspirin-contain	ning therapy?		
understand the benefits and Hennepin Health Systems ts officers, employees, and epresentatives. I acknowled way in which my health in am financially responsible Relationship to part for the self, I am the child'	nd risks of the v s (HHS) dba MV id agents from a ledge that a cop formation may b ole to HHS dba itient: Se s parent, author ny child's school	accination and of NA, its officers, any and all liability of HHS's Notice used or disclosured for any lf OR 6 in trized representation.	expressly authorize a nemployees, agents; and ity that might arise from one of Privacy Practices osed by HHS and of my balance not covered months – 18 year ative, or legal guardian aresponsible adult to be	vaccination on behalf of me, my has available to me, which provides rights with respect to my health in by my insurance company(ies) in rs: Mother Father and can provide effective consent for present at the immunization and to	ne. I hereby rele (company nam leirs and person an explanation iformation. I unc ndicated above  Other for this immuniza	ase e), al of the lersta ation. on or	and
					114MH201303	01	
Manfacturer	Dose	Age	NURSE ONLY Site	Lot number (sticker)	Expiration	n dat	re.
FluLaval/GSK PFS	□ 0.5 mL	□ 6 mo +	IM Deltoid: L or R	200 110111001 (0010101)			.0
Fluarix/GSK PFS	□ 0.5 mL	□ 6 mo +	IM Thigh (infant only): L or R  IM Deltoid: L or R  IM Thigh (infant only): L or R				
Fluzone/Sanofi MDV	□ 0.5 mL	□ 6 mo +	IM Deltoid: L or R IM Thigh (infant only): L or R				
HighDose/Sanofi	□ 0.7 mL	□ 65 yrs +	IM Deltoid: L or R				
FluMist/Medimmune	□ 0.2 mL	□ 2- 49 yrs	Nasal spray				
Vaccine administrato							
RN name (please prin	t)		[	Date//2021 VIS e	dition/_	/_	
EUA Vaccine Fact She	eet given/offere	ed today: 🔲 (F	RN to check box)	Administration compl	ete in Epic?		