

Bill To: _____

Paid: _____

FLU Shot VACCINE RECORD
2008-2009

Cerro Gordo Department of Public Health
22 N. Georgia Ave., Mason City, IA 50401

Please Print Information

NAME _____
(LAST) (FIRST) (Middle Initial)

ADDRESS _____
(Street) (City) (State) (Zip)

BIRTH DATE ____/____/____ AGE ____ SEX: Male / Female (Circle One)
(Month) (Day) (Year)

MEDICARE/MEDICAID # _____ MEDICARE SUPPLEMENT # _____
(Example: 123-45-6789A)

PHONE (____) _____ SOCIAL SECURITY # _____

PHYSICIAN _____

Do You Have a History of Guillain-Barre Syndrome? ____ Yes ____ No ____ Not Sure

Are You Allergic to Eggs? ____ Yes ____ No Are You Allergic to THIMEROSAL? ____ Yes ____ No

“I verify that, to my best knowledge, this information is factual. I have read or have had explained to me the information in the vaccine information statement about the influenza vaccine. I believe I understand the benefits and the risks of the influenza vaccine and ask that the vaccine be given to me.” I also understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information (PHI). The Notice of Privacy Practice has been made available to me which explains those rights.

(Client’s Signature or Legal Representative signature if applicable) (Date)

OFFICE USE ONLY Client needs 2nd dose

Date	Site	Lot #	Nurse’s Signature
	() LD () LT () RD () RT		

Date	Site	Lot #	Nurse’s Signature
	() LD () LT () RD () RT		