



INFLUENZA VACCINATION RECORD

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

DOB: _____ Soc. Sec. #: _____ Sex: _____

Insurance: _____

Please circle the appropriate response below:

- YES NO Are you allergic to eggs?
- YES NO Are you allergic to Thimerosal (Mercury)?
- YES NO Are you allergic to Amino glycosides (Gentamicin)?
- YES NO History of Guillain-Barre' Syndrome?
- YES NO Are you pregnant, or think you might be pregnant?
- YES NO Are you currently ill or running a fever?
- YES NO Do you have a clotting disorder or unexplained bleeding?
- YES NO Have you had a previous reaction to the Influenza Vaccine?

I have read, or had explained to me, the information about Influenza and the Influenza Vaccine on the other side of this form. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the Influenza Vaccine and request that the Vaccine be given to me or the person named above, for whom I am authorized to make this request. I am also aware the immunization does not guarantee that I will develop immunity.

My signature indicates that I hereby release Boerne/Bulverde Urgent Care & Occupational Health Center from any and all liabilities from this vaccine.

Signature of person to receive vaccine or person authorized to make the request Date

FOR CLINIC USE ONLY

Influenza Virus Vaccine 0.5cc IM Site of injection: R deltoid L deltoid

Manufacturer: _____ Lot #: _____

Expire date: _____ Physician: Bryan M. Dunn, MD Brian L. Fowler, MD

For office use: CPT: 90659 ICD9: V04.8

Administered by: _____ Date: _____