2011 Seasonal Influenza Patient Registration Form
YMCA FAMILY CLINICS

Information about the person receiving the vaccination: (please print)

Last Name:	First Name:	M.I.	Birth date:	Age:	Sex:
Address:	City:	State:	Zip:	Phone number:	

Do you have health insurance? Please select one.

- ☐ No, I am currently uninsured
- ☐ Yes, Private Insurance _____
- ☐ Yes, but no vaccine coverage
- ☐ Medicaid # _____
- ☐ Medicare # _____
- ☐ Amount Paid $_____ ☐ Check ☐ Cash ☐ N/C

EVERYONE - Please answer the following questions:

1. Are you sick or do you have a high fever?	☐ Yes ☐ No
2. Have you ever had a severe allergic reaction to eggs, gelatin or latex?	☐ Yes ☐ No
3. Have you ever had Guillian-Barré syndrome?	☐ Yes ☐ No
4. Are you allergic to Thimerosol? (a preservative)	☐ Yes ☐ No
5. If you are female, are you pregnant?	☐ Yes ☐ No
6. Have you had any problems with previous flu shots?	☐ Yes ☐ No

FLU MIST SCREENING QUESTIONS FOR CHILDREN 2 YEARS – 18 YEARS

1. Do any of the following apply to the child to be vaccinated with FluMist? • Allergy to eggs, egg proteins, gentamicin, gelatin or arginine • Life threatening reaction to a previous flu vaccine • Is between 2-17 years of age and currently taking aspirin therapy	☐ Yes ☐ No
2. Does the person to be vaccinated expect to have close contact within the next 7 days with a person whose immune system is so severely compromised that they required a protective environment?	☐ Yes ☐ No
3. Do any of the following apply to the person requesting FluMist? • Asthma • Is under 5 years of age and has recurrent wheezing • Long-term health care problem with weakened immune system, or heart, lung, liver, kidney disease, diabetes, anemia or other blood disorders. • Is pregnant or nursing	☐ Yes ☐ No

Consent:

I have read or have had explained to me the above information and reviewed a copy of the Vaccine Information Statement (VIS) for Influenza vaccine and SRHD HIPAA Privacy Policy. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risk of 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 consent to inclusion of this data in the Washington State Immunization Registry. By signing this consent I am allowing myself and/or my child(ren) to be filmed or photographed during the Influenza immunization clinic today.

_____

Signature of person to receive vaccine (or parent/legal guardian if a minor) Date

_____

If parent/legal guardian, PLEASE PRINT NAME

For Clinic Use Only		
CHILDREN'S VACCINES 6 MONTHS UP TO THEIR 19TH BIRTHDAY		
Infants **6 month – 35 months**	Pre-filled syringe - 0.25ml Sanofi ☐ LD ☐ RD ☐ LT ☐ RT	Lot number: UT4114BA Expiration Date: 6/30/2012 VIS Date: 7/26/11
Children **3 years up to** **their 19th birthday**	Multi-dose vial - 0.50ml Sanofi ☐ LD ☐ RD ☐ LT ☐ RT	Lot number: UT454AD Expiration Date: 6/30/2012 VIS Date: 7/26/11
Healthy Children **2 years up to their 19th birthday**	FluMist – prefilled nasal sprayer MedImmune ☐ IN	Lot number: 501103P Expiration Date: 12/11/11 VIS Date: 7/26/11

For Clinic Use Only		
ADULT VACCINES – 19 years and older		
ADULTS: **19 years and older**	Multi-dose vial - 0.50ml Sanofi ☐ LD ☐ RD ☐ LT ☐ RT	Lot number: UH477AD Expiration Date: 6/30/2012 VIS Date: 7/26/11

Date:	Vaccinator Initials:	Location:	Time with client: 5 min.
			KIPHS#