

Garrisonville Urgent Care

9 Center Street
Suite 101
Stafford, VA 22556

Telephone (540) 288-2222

Influenza Vaccine Registration/Consent Form

1. Name: _____ Date: _____
2. Date of Birth: _____ SS.: _____ Sex: _____
3. Street Address: _____
City/State/Zip Code: _____
4. Home Tel.: _____ Work Tel.: _____
5. Allergy to eggs: Yes/No
6. Previous Flu shot/Date: _____ Allergy to Flu shot: _____
7. Any fever in the last 24 hours? Yes/No Last Menstrual Period: _____
8. Do you have a history of Guillain-Barre' Syndrome (a form of neurological disorder)? Yes/No

Despite a negative history of allergies to eggs and/or Flu shot, patients may still have a serious allergic or adverse reactions to the Flu vaccine, we therefore request that patients remain in the center for at least 30 minutes after the vaccine has been given.

I understand the information above and have had my questions on the vaccine answered. I have also provided the answers to the above questions truthfully. I request that I or my dependent be given the Flu vaccine.

Patient/Parent or Guardian

Date

Patient's Temperature: _____

Lot #: _____

Expiration Date: _____

Route/Site shot was given: _____

Staff Signature: _____

Payment Amount/Method: _____