



Southwest Utah Public Health Department - Flu Vaccine Registration Form

Last Name	First Name	Female	Date of Birth	Age
		Male		
Address		City	State	Zip
Home Phone		Cell Phone	Email	
Hispanic? Yes No	Race: Other _____	White	Asian	Black
		Pacific Islander	Native American/Alaskan Native	
How did you hear about this event?				

Please answer the following questions:

- | | | |
|---|-----|----|
| * Is the person to be vaccinated sick today? (fever or very stuffy nose) | Yes | No |
| * Does the person to be vaccinated have an allergy to eggs, gelatin, thimerosal or other vaccine component? | Yes | No |
| * Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | Yes | No |
| * Has the person to be vaccinated ever had Guillain-Barré syndrome? | Yes | No |
| * Is the person to be vaccinated pregnant? | Yes | No |

CONSENT FOR TREATMENT AND PRIVACY NOTICE

I certify that the information I have provided is true and accurate. I have been given a copy and have read, or have had explained to me, the information contained in the Vaccine Information Statement (VIS) about the disease. 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(s) indicated be given to the person named above for whom I am authorized to make this request. I agree that this information may be shared with schools, daycare centers, health care providers and others when deemed medically necessary.

I hereby release Southwest Utah Public Health Department (SWUPHD), and its employees, from all claims arising from such immunizations. I authorize Medicaid or insurance benefits to be paid to the SWUPHD or its authorized agent and for the SWUPHD or its authorized agent to release information to Medicaid or insurance companies as necessary for claims. I understand that I may be liable for all or a portion of the bill.

X _____ **Date** _____
 Signature of patient or parent/legal guardian

FOR OFFICE USE ONLY									
VFC:	Medicaid	CHIP	No insurance	Am Ind/Ak Nat	Medicaid:	State	Molina	SHCC	HC
Private:	PEHP	SelectHealth	Tall Tree	DMBA	United	Altius	Medicare	Medicare HMO	
Self Pay:	Amt _____		CC	Cash	Chk # _____				

Date	Vaccine	Lot#	Dose	Site	Nurse
	Flu – inject.		.5 mL .25 mL	LD RD LVL RVL	