FLU VACCINE	Cell Phone-	Reviewed by Nurse	
Last Name First Name MI		BIRTH DATE	Age
Address		Doctor	

ADULT FLU IMMUNIZATION CHECKLIST

Y - N **1.** Are you sick with something more than just a cold or had a fever in the last 24 hours?

Y –N **2.** Do you have a disease that lower's the body's resistance to infections?

Y - N **3.** Are you taking any drugs that lower the body's resistance to infection such as Cortisone or Prednisone?

Y - N **4.** Are you allergic to eggs, gelatin or to an antibiotic called Gentamycin Sulfate?

Y - N **5.** Have you ever had Guillain Barre' Syndrome or any other problems after an immunization?

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the "Joint Notice of Privacy Practices" from the Brown County Public Health Department

SIGNATURE ______________________________ DATE __________

FOR OFFICE USE ONLY

Time IN ________ Time Out______

Brown County Health Department 120 E Main Street Mt. Sterling, IL 62353

Date	Vaccine	MFG	Lot number	Route	Site	VIS given	Initials of nurse
				IM			
Route	Site	Initials	Signature of Nurse administering the vaccine				
IM- intramuscular	Rd- Right Deltoid Ld- Left Deltoid						

MEDICARE **State ID** **Private Insurance** **Employer** **CASH**

MEDICARE #______________________________

STATE ID # ______________________________

INSURANCE # ______________________________

EMPLOYER ______________________________

CASH/CHECK ______________________________