FORSYTH COUNTY DEPARTMENT OF PUBLIC HEALTH

FLU CLINIC

2020 ADULT REGISTRATION FORM

PLEASE PRINT / PLEASE PROVIDE COMPLETE NAME

ADULTS (19 YRS. OF AGE AND OLDER)

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME

BIRTHDATE	SEX	HISPANIC?	RACE	TELEPHONE NUMBER
	M / F	Y N		

STREET ADDRESS	APT #

CITY	STATE	ZIP CODE	COUNTY

MOTHER'S FIRST AND MAIDEN LAST NAME

PLEASE CHECK CORRECT ANSWER

1. Any signs of illness/fever today? No___ Yes___ (Describe-_____)
2. Have you ever received flu vaccine before? No___ Yes___ (WHEN?_____)
3. Have you ever had a serious reaction to eggs, gelatin, thimerosal or to a PREVIOUS DOSE of flu vaccine?
   No___ Yes___ (Describe-_____)
4. Do you have a history of Guillain-Barre` Syndrome (a severe paralytic illness)? No___ Yes___
5. Do you have a history of severe allergy to latex? No _____ Yes _____
6. Are you pregnant? No _____ Yes _____
7. Do you have insurance? No_____ Yes _____ □ Medicaid □ Medicare □ Private Insurance

PATIENT CONSENT

I have read or have had explained to me information about the above listed immunizations, vaccines or injections. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the listed immunizations, vaccines or injections and request that they be administered to me or to the person named above for whom I am authorized to make this request.

I hereby acknowledge that I can receive a copy upon request of the "Notice of Privacy Practices" for Forsyth County Department of Public Health and understand that I may contact the person named therein if I have questions about the content of the notice.

_____ _____

PATIENT SIGNATURE DATE

FOR OFFICE USE ONLY

Lot #	Route	Injection Site
Flu S P _____	IM	LD RD

_____ _____ NCIR ☐

VACCINE ADMINISTRATOR SIGNATURE/TITLE DATE

FCDPH 9/14/20