SIERRA COUNTY HEALTH DEPARTMENT
Seasonal Flu Shot Drive-Thru Clinic

PRINT NAME: _____

BIRTH DATE: _____ AGE: _____ PHONE NUMBER: _____

MAILING ADDRESS:_____ZIPCODE:_____

PHYSICAL ADDRESS:_____

EMAIL: _____

| | Yes | No | Don't Know |
|---|---|---|---|
| 1. Is the person to be vaccinated sick today? | ☐ | ☐ | ☐ |
| 2. Does the person to be vaccinated have an allergy to eggs, Neomycin or Thimerosal which is so bad that it needs medical treatment? | ☐ | ☐ | ☐ |
| **3.** Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | ☐ | ☐ | ☐ |
| **4.** Has the person to be vaccinated ever had Guillain-Barre' syndrome? | ☐ | ☐ | ☐ |
| 5. Is the person receiving the shot pregnant or will be pregnant during the flu season? | ☐ | ☐ | ☐ |

6. Where did you hear about the Flu Shot Clinic/Drive Thru?
   Please circle one

   Newspaper County Website Social Media Post Office

   Flyer - Where:_____ Other:_____

- I have read or had explained to me the "Influenza Vaccine Information Statement". I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and request that it be given to me or to the person for whom I am authorized to make this request. I authorize my/my child's Immunizations to be input in the California Immunization Registry.

_____ _____

Signature Date