ANCHOR MEDICAL STAFFING

19220 Lorain Road
Fairview Park, Ohio 44126
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Flu Vaccine Questionnaire/Consent Form

Date: ____/____/____

Patient Name: _____ DOB:_____

1)	Have you had a flu shot before?	YES	NO
2)	Are you sick today?	YES	NO
3)	Are you allergic to eggs?	YES	NO
4)	Do you take asthma medication	YES	NO
5)	Is anyone in your household immune suppressed?	YES	NO
6)	Do you have a chronic medical condition?	YES	NO
7)	Is there a possibility that you may be pregnant?	YES	NO

I have read and received the vaccine information sheet for the Flu Vaccine and Understand the risks and side effects associated with the vaccine.

Patient Signature: _____ Date: ____/____/____

For medical staff use only. Do not write in this area.

Vaccine: ○ Influenza ○ Thimerosol Free **Vaccine Lot Number:** [ ] **Route/Site:** IM ○

Manufacturer/Product Name: _____/_____ **Exp Date:**____/____/____ **Arm:** R ○ L ○

Nurse's Name (Please print):_____ **Title:** ○ **RN** ○ **LPN** ○ **MD** **Dose:** 0.5ml

Nurse's Signature (Sign in ink): _____ **Date:** _____ **Nurse's License #:** [ ]