SUMMIT COUNTY PUBLIC HEALTH INFLUENZA VACCINE
FAMILY FORM

Family Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

PLEASE ANSWER THE FOLLOWING FOR **EACH PERSON** TO BE VACCINATED:

Name (1): _____ Age: _____ DOB: _____

1. Are you currently ill and/or do you have a fever? _____YES _____NO
2. Do you have any allergies (to eggs, medications, other?) _____YES _____NO
3. Have you had serious reaction to flu vaccine in the past? _____YES _____NO
4. Have you had Guillain-Barre Syndrome? _____YES _____NO

Name (2): _____ Age: _____ DOB: _____

1. Are you currently ill and/or do you have a fever? _____YES _____NO
2. Do you have any allergies (to eggs, medications, other?) _____YES _____NO
3. Have you had serious reaction to flu vaccine in the past? _____YES _____NO
4. Have you had Guillain-Barre Syndrome? _____YES _____NO

Name (3): _____ Age: _____ DOB: _____

1. Are you currently ill and/or do you have a fever? _____YES _____NO
2. Do you have any allergies (to eggs, medications, other?) _____YES _____NO
3. Have you had serious reaction to flu vaccine in the past? _____YES _____NO
4. Have you had Guillain-Barre Syndrome? _____YES _____NO

Name (4): _____ Age: _____ DOB: _____

1. Are you currently ill and/or do you have a fever? _____YES _____NO
2. Do you have any allergies (to eggs, medications, other?) _____YES _____NO
3. Have you had serious reaction to flu vaccine in the past? _____YES _____NO
4. Have you had Guillain-Barre Syndrome? _____YES _____NO

Name (5): _____ Age: _____ DOB: _____

1. Are you currently ill and/or do you have a fever? _____YES _____NO
2. Do you have any allergies (to eggs, medications, other?) _____YES _____NO
3. Have you had serious reaction to flu vaccine in the past? _____YES _____NO
4. Have you had Guillain-Barre Syndrome? _____YES _____NO

PLEASE SIGN ON REVERSE

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Public Health

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I have read or have had explained to me the information regarding the vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request. I was offered a copy of Notice of Privacy Practices from Summit County Public Health.

Signature ____ Date ____________________________

Relationship to client: ____

For clinic use below this line   for clinic use below this line   for clinic use below this line

NAME 1 Initials	Eligibility	Immunization Date	Dose Choose one:	Site	Lot Number	Administered By
	___VFC ___317 ___PP ___CR		____ 0.25 mL QIV Ped (6-35 months) ____ 0.5 mL QIV SD (6 months +) ____ 0.5 mL High Dose (65+) ____ other: ________________	LD RD LVL RVL		

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