THE URGENT CARE WALK-IN CLINIC
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FLU SHOT QUESTIONNAIRE

DATE: ___/___/_____

NAME: _____ DATE OF BIRTH: ___/___/_____

ADDRESS: _____ PHONE NUMBER: _____

_____ HOW DID YOU HEAR ABOUT US? _____

PRIMARY INSURANCE: _____ POLICY HOLDER: _____

MEMBER ID: _____ GROUP #: _____

CONTRAINDICATIONS TO THE FLU SHOT

	YES	NO
1. Are you in the first trimester of pregnancy?	___	___
2. Are you allergic to eggs or chicken feathers?	___	___
3. Are you ill or have fever?	___	___
4. Have you ever had a reaction to the flu vaccine?	___	___
5. Have you ever had Guillian Barre Syndrome?	___	___

If you answered "YES" to one of the questions above, you cannot receive a flu shot!

By signing here, I am stating that I have read, fully understand, and agree with the urgent care's HIPAA patient consent policy, patient responsibility policy, and consent for treatment policy, provided by staff.

I am also stating that I do not have any contraindications to the flu shot.

Patient Signature: _____

OFFICE USE ONLY:

Lot #: _____
Time: _____
Deltoid: _____

Date: ___/___/_____
Given By: _____
Temp: _____

FLUZONE QUAD 90686 90471 FLUZONE MCR Q2038 G0008 FLUZONE HIGH DOSE 90662 G0008