# Flu Vaccination Registration Form

The following questions will help determine if there is any reason we should not give you (or your child) the flu vaccine. Answering "yes" to any question does not necessarily mean you (or your child) should not be vaccinated. It simply means additional questions must be asked. If a question is unclear, please ask your healthcare provider to help explain.

## Patient information

**First name** | **Last name**

**Suffix** (optional) | **Date of birth** (MM/DD/YYYY) | **Age**

**Parent/guardian first name**

## Contact information

**Mailing address** | **City** | **Zip code**

**Mobile number** | **Email address**

## Gender

- [ ] Female
- [ ] Male
- [ ] Non-binary
- [ ] Prefer not to say

## Hispanic, Latino, or Spanish origin

- [ ] Argentinian
- [ ] Colombian
- [ ] Costa Rican
- [ ] Cuban
- [ ] Honduran
- [ ] Guatemalan
- [ ] Hispanic, Latino/ Spanish Origin
- [ ] Mexican, Mexican American, Chicano
- [ ] Nicaraguan
- [ ] Panamanian
- [ ] Peruvian
- [ ] Puerto Rican
- [ ] Salvadorian
- [ ] Other South American
- [ ] Other
- [ ] Not of Hispanic, Latino or Spanish origin
- [ ] Prefer not to say

## Race/nationality (check all that apply)

- [ ] American Indian or Alaska native
- [ ] Asian Indian
- [ ] Bangladeshi
- [ ] Black or African American
- [ ] Cambodian
- [ ] Chamorro
- [ ] Chinese
- [ ] Fijian
- [ ] Filipino
- [ ] Guamanian
- [ ] Hawaiian
- [ ] Hmong
- [ ] Indonesian
- [ ] Japanese
- [ ] Korean
- [ ] Laotian
- [ ] Malaysian
- [ ] Marshallese
- [ ] Middle Eastern or North African
- [ ] Pakistani
- [ ] White
- [ ] Other

## Health insurance

**Do you have health insurance?** ☐ Yes ☐ No

**If yes,**

| | |
|---|---|
| **Insurance provider** | **Primary carrier's full name** |
| **Relationship with primary carrier** | **Policy number** |

## Medical screening questions

| | | |
|---|---|---|
| **Is the patient feeling sick today?** | ☐ Yes | ☐ No |
| **Does the patient have an allergy to an ingredient of the influenza vaccine?** | ☐ Yes | ☐ No |
| **Has the patient ever had a serious reaction to influenza vaccine in the past?** | ☐ Yes | ☐ No |
| **Has the patient ever had Guillain-Barre Syndrome (GBS)?** | ☐ Yes | ☐ No |

## Information on the risks and benefits of the flu vaccine

CDC recommends everyone 6 months and older get vaccinated every flu season. Children 6 months through 8 years of age may need 2 doses during a single flu season. Everyone else needs only 1 dose each flu season. To learn more about the risks, benefits, and side effects of flu, read the CDC Vaccine Information Statement.

## Minor consent

I declare that I am (must check one):

☐ **The parent of the named minor child.**

☐ **The legal guardian of the named minor child.**

☐ **An emancipated minor at least 16 years of age.**

☐ **A person with authority to make healthcare decisions on behalf of the named minor child.**
**Describe legal relationship here:** _____

## I attest to the following

All boxes must be checked in order for the minor to be vaccinated:

☐ **I have read and understand the Vaccine Information Statement for the requested vaccine and understand the risks and benefits.**

☐ **I GIVE CONSENT for the minor patient to receive the vaccine.**

## I attest to the following (Continued)

- [ ] **I understand that by providing my voluntary consent, the minor patient can receive the vaccine with or without a parent or guardian being physically present at the vaccination appointment.**

- [ ] **I consent to and authorize all medically necessary treatment in the rare event that the minor patient has a reaction to the vaccine.**

## Parent/guardian information

**Please write your full name**

**Email address** | **Mobile number**

**Address** (Street number & name, City, State, Zip code)

By signing my name and today's date below, I am providing consent for the named minor child to receive the flu vaccine and certify that (1) I am authorized to provide this consent and (2) all of the information I have provided on this form is true and correct to the best of my knowledge:

**Parent/guardian signature** | **Date signed** (MM/DD/YYYY)

### *For staff use only*

**Name** | **Signature**

**Date** | **Time** | **Clinic**

**Product** | **Dose no.** | **Dose** (ML) | **Asset name**

**Injection site:** RD LD RL LL **Route:** IM SQ