Westside Primary Care Associates

Main Location: 14420 W. Meeker Blvd, Suite 207, Sun City West, AZ 85375
Buckeye Office: 865 S. Watson Road, Suite 108 Buckeye, AZ 85326
Phone: 623-267-6700 **Fax:** 623-267-6701 **Web:** westsidepca.com

Flu Vaccine Form

Patient Name:_____

Date:_____ [ ] F [ ] M

DOB: _____ Age:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

I, the undersigned, have read or had explained to me the vaccine information sheet (VIS). I understand the risks and benefits associated with the influenza vaccine and have had any questions satisfactorily answered. I voluntarily request that the vaccine be given to me or for the aforementioned person for whom I am authorized to make this request.

_____ _____

Signature Date

Screening Questionnaire

Are you currently ill or do you have a fever?	Yes	No	Unknown
Have you received the vaccine before?	Yes	No	Unknown
Have you had a reaction to the vaccine before?	Yes	No	Unknown
Have you been sick in the last 2 weeks?	Yes	No	Unknown
Are you allergic to egg or dairy products?	Yes	No	Unknown
Are you allergic to thimerosal?	Yes	No	Unknown
Are you pregnant?	Yes	No	Unknown
Are you a Health Care worker?	Yes	No	Unknown
Have you ever had Guillain-Barre syndrome?	Yes	No	Unknown
Do you have a blood-clotting disorder?	Yes	No	Unknown
Are you taking blood-thinning medication?	Yes	No	Unknown

FOR OFFICE USE ONLY

Date Given:_____ Manufacturer & Lot# _____

Exp. Date:_____ Site: RT LT RD LD

Route:_____ Administered By:_____

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