Start Time _____ End Time _____

IMMUNIZATIONS REGISTRATION / RELEASE FORM
(Please fill out information completely)

Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____ Age _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Gender { } Male { } Female

{ } American Indian or Alaska
{ } Asian Indian
{ } Black or African American
{ } Chinese
{ } Filipino
{ } Guamanian
{ } Hawaiian
{ } Japanese
{ } Korean
{ } Other Pacific Islander
{ } Other Non-White
{ } Other Asian
{ } Unknown
{ } Samoan
{ } Vietnamese
{ } White

_____
Last 4 digits of Social Security Number (Optional)

1. Is the person being vaccinated sick today? ☐ Yes ☐ No
2. Does the person being vaccinated have any serious allergies? Yes ☐ No ☐
   If Yes, Please List:_____
3. Has the person being vaccinated ever had serious reaction to a vaccine in the past? ☐ Yes ☐ No
4. Has the person being vaccinated ever had Guillain-Barré Syndrome? ☐ Yes ☐ No

Service Requested: ☐ Flu ☐ Flu Hi Dose ☐ Other _____

I have requested vaccination services from the Florida Department of Health in Hillsborough County as indicated above. I have received and understand information provided in the Vaccine Information Statement.

Medicaid (Insurance Information):____N/A_____

Today's Date:_____

Name of Legal Representative: _____

Relationship to Client: _____

OFFICIAL USE ONLY

FLU (IM) VIS - 08/15/19	L DELT R DELT LOT #		FLU HI DOSE (IM) VIS - 08/15/19	L DELT R DELT LOT #
OTHER (IM) VIS - 08/15/19	L DELT R DELT LOT #			

NURSE ADMINISTRATOR / VACCINATOR

{ } A. James { } A. Santiago { } G.Taylor { } D.Jackson { } L. Chisholm { } M. Ortega-Aleman

{ } M. Lavin-Rives { } G. Brown { } J. Gallo { } Other _____