Kenneth M. Klebanow, MD & Associates P.A.

Influenza Vaccine Form

Name: _____ **Gender**:___ **DOB**:_____ **Age**:_____

Address: _____ **Phone**: _____

City: _____ **State**: _____ **Zip Code**: _____

Please circle Yes or No:

Have you/ your child/ household member experienced any of the following in the last 5 days?

1. Any symptoms of illness? **Yes** **No**
2. Positive COVID result? **Yes** **No**

****IF YOU ANSWER YES TO ANY OF THE ABOVE QUESTIONS PLEASE CALL THE OFFICE AT **410-997-1700****

1. Are you allergic to eggs**? Yes No** Can you eat baked eggs? **Yes** No
2. Do you have any allergies to medications or vaccines? **Yes No** If yes, what: _____
3. Have you ever had a serious reaction after receiving a flu vaccine or any other vaccine? **Yes No**
4. Do you have a history of Guillain- Barre Syndrome? **Yes No**
5. Are you allergic to latex? Yes No

I have received and read the Vaccine Information Statement (VIS) and/ or have had explained to me information about the disease and the vaccine. There was an opportunity to ask questions and any questions were answered satisfactorily. I understand the benefits and the risks of the vaccines cited, and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I further understand that insurance may not cover this vaccination and I may be responsible for full payment. ** **For Adults receiving the vaccination**: I understand that this is cash and carry. I understand that neither I, nor your company will be submitting to insurance.**

Parent or Guardian Signature : _____ **Date**: _____

For office use:

Date of last flu vaccine: _____

☐ Preservative Free (6mo+) ☐ Multi Dose

☐ VFC Single Dose

VIS Publication Date 8/6/21

Manufacturer: _____ Temp: _____

Lot #: _____ Exp. Date: _____ Site of Injection: _____

Insurance: _____ Amount paid: _____ Payment Type: Cash Check Credit Front

Desk: _____ Nurse: _____ Date: _____