Sioux Center Health
An Avera Partner

Sioux Center Medical Clinic
1101 Ninth St SE
Sioux Center, IA 51250
712-722-2609

Hull Medical Clinic
807 Main Street, Ste. D
Hull, IA 51239
712-439-1315

For Office Use Only:
☐ IRIS
☐ HM
Acct #_____

INFLUENZA IMMUNIZATION RECORD

Name _____ Date of Birth _____
(Please print)

Address _____ SSN _____

City _____ State _____ Zip _____ Phone _____

MEDICAL INFORMATION:	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have an allergy to eggs or to a component of the vaccine?	☐	☐	☐
3. Have you ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Have you ever had Guillain-Barre' syndrome?	☐	☐	☐

POSSIBLE SIDE EFFECTS:

Immediate:
a. Red, raised area at the site of injection lasting 1 to 2 days.
b. Respiratory distress could occur when an individual is allergic to eggs.

Short-term:
a. Fever, weakness, and/or aches. Will most likely start 6 to 12 hours after receiving the vaccine and persist for 1 to 2 days. This can occur when the body is developing immunity.

Long-term:
a. No proven association with Guillain-Barre' Syndrome with flu vaccine.

Flu Vaccine Authorization & HIPAA Acknowledgement

I have been provided a copy of and/or have read or have had explained to me, information about an Influenza Vaccine Fact Sheet. I have had a chance to ask questions that were answered to my satisfaction.

I hereby request that an influenza vaccination be administered to me. All viruses in the vaccine are killed so you cannot get influenza from the vaccine. I understand that there is a possibility of an allergic or more serious reaction, or even death could occur with the flu shot.

A *Notice of Privacy* has been made available for me to review.

Signature of person to receive vaccine/guardian if minor/person authorized to make the request:

X_____ Date _____

For Office Use Only

Clinic Site:
☐ S.Center
☐ Hull

Site of Administration:
L or R Deltoid
L or R Thigh

Self Pay:
☐ Check #_____
☐ Cash $_____

Please Place Influenza Vaccine Label Here

Card Scans:
☐ Medicare/MADV
☐ Insurance
☐ Medicaid

Vaccine Given:
☐ Fluzone: Peds Dosage 6-35 mos (0.25ml)
☐ Fluzone: 3 yrs – Adult Dosage (0.5ml)
☐ Pneumococcal Vaccine

Please Place Pneumococcal Vaccine Label Here

Immunizer Signature _____ Date of Administration _____