********* City of El Paso Department of Public Health **********

5115 El Paso Dr. El Paso TX. 79905

(PRINT PLEASE)

Last Name: **First Name:** **Middle Name:** **Age:**

Gender: **M** ☐ **F** ☐ **Pregnant:** **Y** ☐ **N** ☐ **Suspected** ☐ **Race:** **Date of Birth (MM/DD/YYYY):**

Address: **City:** **State:** **Zip Code:**

Phone Number: **Vaccination Clinic Location:** **Date (MM/DD/YYYY):**

INSURANCE

- ☐ No Health Insurance
- ☐ Private Insurance (BC/BS, Aetna, etc…)
- ☐ Medicare
- ☐ Medicaid
- ☐ CHIP

HOUSEHOLD INCOME **HOUSEHOLD SIZE** _____

- ☐ Less than $20,000
- ☐ 20,001-40,0000
- ☐ 40,001-60,000
- ☐ 60,001-80,000
- ☐ 80,000-100,000
- ☐ More than 100,000

MEDICAL HISTORY	YES	NO
1. Is the patient (Child or Adult) sick today?		
2. Does the patient have a severe allergy to eggs that required hospitalization?		
3. Has the patient had a severe reaction to Flu vaccine in the past?		
4. Has the patient had a condition called Guillain Barre Syndrome (GBS)?		
5. Is the patient under isolation for COVID-19 at this moment?		
6. Has a physician or medical provider indicated NOT to receive this vaccine?		

I know that the person receiving the vaccine will have the vaccine put into his/her body to prevent the infectious disease.

- *I am an adult who can legally consent for the person named above to get the vaccine.*
- *I freely and voluntarily give my signed permission for the vaccines.*

The individual or legal guardian of the above person has been informed of the benefits and risks of the vaccine(s) and consents for the identified person to be immunized Yes ☐ No ☐

Patient/Parent or Legal Guardian Name: _____ Signature: _____

Relationship to the Patient: _____ Date: _____

*****CLINIC USE ONLY*****

Date Given	Vaccine Given	Mfg	VIS Date	Lot #	Site Used	Adm. Title/signature
	Influenza					