AHP Flu Clinic 2020 **INACTIVATED FLU FORM** Date: _______________ Type of Insurance ______________________________________

Patient name				
Patient DOB				
1. Have you had any recent (past 14 days) exposure to a person who tested positive for COVID?				
2. Having any symptoms related to COVID? (fever, sore throat, cough, loss of taste / smell)				
3. Do you have/have had any severe (life threatening) allergy to eggs or a previous dose of flu?				
4. Do you have Guillain-Barre Syndrome (a severe paralytic illness)?				
5. Are you experiencing any moderate or severe illness today, including any fever?				
6. Do you have a history of severe reaction to latex?				
7. Do you have questions regarding the Influenza Vaccine Information Statement? (give copy if didn't already read online)				
Below is To be completed by AHP staff				
TEMPERATURE				
Lot# / expiration date				
Injection site		L arm R arm L leg R leg	L arm R arm L leg R leg	L arm R arm L leg R leg
Initials of vaccine admin				