



# LAFAYETTE COUNTY HEALTH DEPARTMENT

## FLU CONSENT

**Public Health**  
Prevent. Promote. Protect.

**OUTREACH LOCATION: Emerg. Prep Drive-thru**

### Personal Information—PLEASE PRINT

LAST NAME	FIRST NAME	M.I.
_____	_____	_____

DATE OF BIRTH : _____	AGE : _____	GENDER M <input type="checkbox"/> F <input type="checkbox"/>
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MAILING ADDRESS :  
\_\_\_\_\_

CITY	STATE	ZIP
_____	_____	_____

PHONE NUMBER: _____	MEDICARE NUMBER _____
	MEDICAID NUMBER _____

RACE: (Circle One)

Amer Ind. or Alaska Native	Asian	Black or African American
Hispanic	White	Biracial
		Other

### FLU SCREENING QUESTIONS:

- Has the person to be vaccinated ever had Guillian Barre Syndrome or any other neurological disease? \_\_\_\_\_YES \_\_\_\_\_NO
- Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? \_\_\_\_\_YES \_\_\_\_\_NO
- Is the person allergic to latex? \_\_\_\_\_YES \_\_\_\_\_NO

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

### FOR OFFICE USE ONLY