FORSYTH COUNTY DEPARTMENT OF PUBLIC HEALTH

FLU CLINIC

2021 CHILDREN'S REGISTRATION FORM

(AGES 6 MONTHS THROUGH 18 YEARS)

CHILD'S PHYSICIAN

LAST NAME	FIRST NAME	MIDDLE NAME

BIRTHDATE	AGE	SEX M / F	TELEPHONE NUMBER	RACE

STREET ADDRESS	APT#	PARENT/GUARDIAN'S NAME

CITY	STATE	ZIP CODE	COUNTY

MOTHER'S MAIDEN NAME

PLEASE CHECK ONE: (This informations is for federal funding purposes only. It will not prevent your child from receiving vaccine through this program. *THANK YOU* for taking the time to provide this information.)

My child: ☐ has Medicaid (S) ☐ is not insured (S) ☐ is Native American or Alaskan Native (S)

☐ insured by NC Health Choice (P) ☐ is insured (P)

PLEASE CHECK CORRECT ANSWER

1. Any signs of illness/fever today? No___ Yes___ (Describe-_____)
2. Has your child received flu vaccine before? No___ Yes___ (When?_____)
3. Any serious reactions to eggs, gelatin, thimerosal or to a PREVIOUS DOSE of flu vaccine?
   No___ Yes___ (Describe-_____)
4. Does child have a history of Guillain-Barre` Syndrome (a severe paralytic illness)? No___ Yes___
5. Does child have a severe allergy to latex? No _____ Yes _____

PATIENT CONSENT

I have read or have had explained to me information about the above listed immunizations, vaccines or injections. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the listed immunizations, vaccines or injections and request that they be administered to me or to the person named above for whom I am authorized to make this request.

I hereby acknowledge that I can receive a copy upon request of the "Notice of Privacy Practices" for Forsyth County Department of Public Health and understand that I may contact the person named therein if I have questions about the content of the notice.

_____ _____

PATIENT SIGNATURE DATE

FOR OFFICE USE ONLY

		Lot #	Route	Injection Site			
PFS ☐	S P	_____	IM	LD	RD	LD	RD
MDV 0.5 ☐							

_____ _____ NCIR ☐

VACCINE ADMINISTRATOR SIGNATURE/TITLE DATE

FCDPH 9/14/20