



420 W. 15th Ave.,  
Emporia, KS 66801  
620.342.4864  
www.flinthillshealth.org

Name: \_\_\_\_\_ Sex: M F D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_  
(Please Print)

Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

Primary Care Provider and City: \_\_\_\_\_

- 1. Are you sick today? \_\_\_yes \_\_\_no
- 2. Do you have allergies to eggs or neomycin? \_\_\_yes \_\_\_no
- 3. Have you ever had a serious reaction after receiving a vaccine? \_\_\_yes \_\_\_no
- 4. Have you been diagnosed with Guillain-Barre' syndrome? \_\_\_yes \_\_\_no

I have read or been offered the "Vaccine Information Statement". I give permission to have the following vaccination done and billed under the direction of Flint Hills Community Health Center/Lyon County Health Department and authorization to release this record to the primary care provider listed above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient or parent/guardian of minor child

**Office Use Only**

Ext.: RD  LD  RVL  LVL  Route: IM Nasal VIS Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Manufacturer/Lot Number/Expiration Date

Medication Dispensed

Fluzone	MedImmune
---------	-----------

Insurance Name/ID \_\_\_\_\_ Subscriber DOB \_\_\_\_\_

Cash: \$ \_\_\_\_\_ Check: # \_\_\_\_\_ Medicare: \_\_\_\_\_ Medicaid: \_\_\_\_\_ VFC ELIGIBLE