



LYON COUNTY HEALTH DEPARTMENT

CONSENT FOR VACCINATION

Name: _____ D.O.B _____ Age: _____
(Please Print)

Address: _____ City: _____ County: _____

State: _____ Zip: _____ Telephone: _____

- 1. Are you/child sick today? ___yes ___no
2. Do you/child have allergies to eggs or neomycin? ___yes ___no
3. Have you/child ever had a serious reaction after receiving a vaccine? ___yes ___no
4. Have you/child 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 under the direction of Flint Hills Community Health Center/Lyon County Health Department.

Signature: _____ Date: _____
Patient or parent/guardian of minor child

Office Use Only

Ext.: RD [] LD [] RVL [] LVL []

Route: IM VIS Date: _____

Provider Signature: _____

Manufacturer/Lot Number/Expiration Date

Medication Dispensed

[Empty box for Manufacturer/Lot Number/Expiration Date]

Fluzone

Cash: \$ _____ Check: # _____ Medicaid: _____ Medicare: _____