WESTSIDE PEDIATRICS

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FAST TRACK FLU CLINIC REGISTRATION FORM

PATIENT NAME: _____ TODAY'S DATE: _____

CONTACT #: _____ DOB: _____

FEVER OR ILLNESS IN THE LAST 24 HOURS? ☐ NO ☐ YES

ALLERGY TO EGGS OR COMPONENT OF VACCINE? ☐ NO ☐ YES

SERIOUS REACTION TO FLU VACCINE IN THE PAST? ☐ NO ☐ YES

PARENT/GUARDIAN SIGNATURE _____

PATIENT SIGNATURE (18 YEARS OR OLDER ONLY) _____

(for official use only)

☐ L Deltoid
☐ R Deltoid
☐ L thigh
☐ R thigh