Vaccination Outreach Registration/Screening Form: VFC Flu Clinic
Ottawa County Department of Public Health

Patient name _____DOB: ___/___/_____
Last (Legal) First Middle

Any previous names: _____ Gender: _____

Address: _____
Street City

_____
State Zip Code County

Parent/Guardian Name: _____License # _____
Last First

Home Phone: _____Cell Phone: _____ Child's Physician _____

Race: _____ Hispanic (circle): Yes No Primary Language: _____

Uninsured: Y / N Underinsured: Y /N Medicaid: Y /N Medicaid # :_____

Commercial Insurance : Y / N Insurance Company_____ Policy # _____

	Yes	No	Doesn't apply
Is your child sick today? (Fever, sore throat, diarrhea, nausea, vomiting,cough)	_____	_____	
Have they ever had a serious reaction to any vaccine in the past?	_____	_____	_____
Have they ever had Guillain-Barre syndrome?	_____	_____	_____
Do they have a history of asthma?	_____	_____	_____
Have they been taking any antiviral medications?	_____	_____	_____
Have they had any vaccines in the last 4 weeks?	_____	_____	_____
Do they have any allergies to foods or medicines?	_____	_____	_____

If yes, what?_____

****For Health Department Use:**

Vaccine: _____ Vaccine administration date_____

Lot number: _____ Site: _____ Route: _____

Clinic name: _____ Signature of Vaccinator _____

Date Processed: _____ PatID#_____ Date Received: _____