ATSU Gutensohn Clinic

800 W. Jefferson St., Kirksville, MO 63501
Kirksville Family Medicine (660) 626-2222 • Neurobehavioral Sciences (660) 626-2182
Osteopathic Manipulative Medicine (660) 626-2304 • Women's Health (660) 626-2211

The doctor or clinic may keep this record in your medical file or in your child's medical file. They will record when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the signature and title of the person who gave the vaccine, and the clinic where the vaccine was given.

I have read or have had explained to me the information on the Influenza Information Statement Form 2016-2017 about influenza and influenza vaccine. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

Information about Person to Receive Vaccine (Please Print)

Last Name	**First Name:**	**MI:**	**Birthdate:**	**Age:**
Address:	**Telephone Number:**		**Sex:** **M / F**	
City	**County:**		**Zip Code:**	
CLINIC USE ONLY:	**Date Vaccinated:**		**Manf Lot Number:**	
Title of Vaccine Admin: **LPN RN**	**Signature of V Admin**		**Deltoid:** **Left Right**	

Patient Signature _____ **Date** _____

Please select one of the following:

☐ ATSU Employee
☐ Biomedical Sciences Student
☐ KCOM Student
☐ Truman State University Employee

(OVER)

Screening Checklist for Contraindications to Vaccines for Adults

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
Are you sick today?			
Do you have allergies to medications, food, a vaccine component or latex?			
Have you ever had a serious reaction after receiving a vaccination?			
Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?			
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems?			
In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, p1-ednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
Have you had a seizure or brain or other nervous system problem?			
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
For women: Are you pregnant or is there a chance you could become pregnant during the next month?			
Have you received any vaccinations in the past 4 weeks?			
Did you bring your immunization record card with you? It is important for you to have a personal record of your immunizations. If you do not have one, ask your provider do give you one. Keep this record in a safe place and bring it with you ever time you seek medical care.			

Form Completed By: _____ **Date:** _____

Form Reviewed By: _____ **Date:** _____