

ALAMAR HEALTHCARE, Inc.

PROVIDER JEFFREY ALLAN, M.D. AVAN PATEL, MD _____

INFLUENZA VACCINATIONS BRIEF FORM Seasonal Flu Swine Flu Inj. Swine Nasal

Your answers on this form will help us understand your medical concerns and conditions better. Best estimates are O.K. if you cannot recall specific details. If you have questions, please ask us. We are happy to help. Thank you!

Today's Date ____ / ____ / 20____ Who referred you to us? Name _____ City _____

Patient First Name _____ Last Name _____ Soc Sec # _____ Birth Date ____ / ____ / 19 ____

Home Address _____ Apt. ____ City _____ State (CA) _____ Zip _____ Home Phone # (____) _____

Emergency Contact Person _____ Emergency Contact Phone (____) _____ Is This A Cell Phone? Y N

Gender: F M Primary Ins Co. _____ Policy I.D. _____ Secondary Ins. Co. _____ Policy I.D. _____

Is your current health Good Fair Poor? Comments: _____

Name(s) of other physicians / providers / practices caring for you? _____

Are you pregnant? Y N Present Health Concerns: _____

If vaccination(s) patient is a minor under 18 years of age, fill out name and address information for parent / guardian of minor

First Name _____ Last Name _____ Soc Sec # _____ Birth Date ____ / ____ / 19 ____

Home Address _____ Apt. ____ City _____ State (CA) _____ Zip _____ Home Phone # (____) _____

ALLERGIES OR REACTION TO injection(s), vaccination(s), medicines, foods, other agents especially eggs and latex

MEDICATION, eggs, latex, vaccination(s) or other	REACTION OR SIDE EFFECT	Please note egg allergies or past bad flu vaccination(s) injectitons / flu nasal mist reactions!

Date of Last Seasonal Flu Immunization ____ / ____ / 20____ Date of Last Swine Flu Immunization ____ / ____ / 20____

CURRENT MEDICATIONS: PRESCRIPTION, OVER-THE-COUNTER, VITAMINS, ALTERNATIVE REMEDIES, HERBS

Medication name	Dose	Times Per Day	Medication name	Dose	Times Per Day

FOR MINOR CHILDREN ONLY - FORM MUST BE SIGNED BY PARENT/GUARDIAN OF MINORS UNDER AGE 18

AUTHORITY TO CONSENT FOR HEALTH CARE TREATMENT I, (print parent/guardian first name and last name here) _____, having been fully informed as to the procedure and risks accompanying dead virus vaccination or live attenuated nasal Flumist vaccination(s) of my minor child, (Child's name) _____, and possessing the full legal authority to consent for health care treatment of this minor child, hereby authorize & consent for Alamar Healthcare, Inc. to provide health care services for my minor child; specifically I authorize the administration of a dead virus influenza "Flu" injection OR live attenuated nasal Flumist vaccine administration to the minor herein identified.

(Parent/Guardian signature) _____ Date: _____, 20____

CONSENT TO TREATMENT FOR ADULTS

I, {your first and last name here} _____, having been fully informed as to the procedure and risks accompanying dead virus influenza "Flu" vaccination(s) or live attenuated nasal Flumist vaccination(s), authorize and consent to treatment; specifically to the staff of Alamar Healthcare, Inc. to administer a dead virus influenza "flu" injection(s) or live nasal Flumist vaccine(s) to me.

(Patient/Legal conservator signature) _____ Date: _____, 20____

FOR OFFICE USE ONLY BY IMMUNIZATION(S) ADMINISTRATOR

____ I have verbally reviewed the medical information above with the patient/guardian and informed the patient/legal guardian as to the procedure and risks accompanying influenza "flu" vaccination(s). Initials _____ Date ____ / ____ / 20____

____ I have attached Influenza Flu Vaccine Sticker(s) With Lot #, Date, injection(s) A13Site, Dosage, My Initials _____ Date ____ / ____ / 20____