**Vaccine Acknowledgment & Consent Form Crawford County Health Department**
**410 E. Atkinson Pittsburg, Kansas 66762**
**Phone (620)231-5411 Fax (620) 231-1246**

## Patient Information (Please Print)

**Patient's Legal Name:**_____ **Age:**_____ **Birthdate:**_____

**Street Address:**_____**City:**_____**State:**_____**Zip Code:**_____

**Phone Number:**_____ **Gender:**_____ **Race:**_____ **Hispanic/Latino: Yes**_____ **No**_____

### Vaccine Screening Questions

Does the person to be vaccinated have a history of severe allergic reaction to the covid vaccine or its components? _____Yes _____No

Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine? _____Yes _____No

**Vaccines Requested:** ☐ Covid ☐ Flu/Influenza

_____ _____ _____ Self

**Signature of Patient or Parent/Guardian** **Date** **Print Name** **Relationship**

End of patient portion.

| Vaccine | Dose | EXT | Site | Route | VIS Date | Lot # | Exp Date |
|---|---|---|---|---|---|---|---|
| Spikevax - Covid | | Rt Lt | Deltoid | IM | | | |
| Flulaval Fluzone HD | | Rt Lt | Deltoid | IM | | | |

_____ _____

**Signature and Title of Person Administering** **Date**