Sioux Center Health
An Avera Partner

Sioux Center Medical Clinic
1101 Ninth St SE
Sioux Center, IA 51250
712-722-2609

Hawarden Medical Clinic
920 Ave F
Hawarden, IA 51023
712-551-1000

Hull Medical Clinic
807 Main Street, Ste. D
Hull, IA 51239
712-439-1315

For Office Use Only:
☐ Walk In
☐ IRIS
☐ HM

INFLUENZA IMMUNIZATION RECORD

Name _____ Date of Birth _____ Age _____
(Please print)

Address _____

City _____ State _____ Zip _____ Phone _____

MEDICAL INFORMATION:	Yes	No	Don't Know
1. Have you ever received an influenza vaccination (including intranasal)	☐	☐	☐
2. Have you ever had a serious reaction to influenza vaccination (including intranasal)	☐	☐	☐
3. Do you have a fever (over 100)?	☐	☐	☐
4. Are you currently COVID-19 positive?	☐	☐	☐
5. Are you allergic to a component of the vaccine?	☐	☐	☐
6. Do you have a history of Guillain-Barre Syndrome within 6 weeks of receiving the influenza vaccine?	☐	☐	☐

I consent to receive the influenza vaccine.

I have received and read the influenza Vaccine Information Sheet. I have been provided an opportunity to ask questions about the disease and the treatment. I understand the risks and benefits of the vaccination, however, with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I hereby request the influenza vaccine.

Signature of person to receive vaccine/guardian if minor/person authorized to make the request:

X_____ Date _____

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Clinic Site:
☐ Sx Center
☐ Hull
☐ Hawarden

Site of Administration:
L or R Deltoid
L or R Thigh

Self Pay:
☐ Check #_____
☐ Cash $_____

Please Place Influenza Vaccine Label Here

Card Scans:
☐ Medicare/MADV
☐ Insurance
☐ Medicaid/MCO

Vaccine Given:
☐ Flu vaccine (6mo+): (0.5ml)
☐ Flu vaccine (65yr +) High dose

Stock:
☐ Private
☐ VFC

Immunizer Signature _____ Date of Administration _____