Brown County Public Health

Free Community Flu Clinic - Appointment Required

December 19, 2020 10:00am to 2:00pm

Brown County Community Services Building - 1117 Center St., New Ulm

507-233-6820

Please complete one of the following forms - **Injectable Flu Vaccine** Or **Flu Mist (Nasal)**

If you have any of the following YOU *DO NOT* qualify for MIST

- Under age 2 or over age 49
- Long term heart disease
- Lung disease (including asthma)
- Kidney disease
- Liver disease
- Neurological Disease
- Metabolic Disease (diabetes)
- Currently pregnant
- If you answer “YES” to any of the above, please fill out the injectable administration form

Influenza Injectable Administration Form

Public Health
Prevent. Promote. Protect.

Enter Contact Information, click submit on bottom of page or print form and bring it to the clinic.

Contact Information - person being vaccinated

Last Name | First Name | Middle I | Gender ☐ Male ☐ Female | Date of Birth

Street Address | City | State | Zip Code | Phone Number

Email Address

Influenza information may be shared through the Minnesota Immunization Information Connection (MIIC) with other healthcare providers, schools, health departments, and others authorized under law to receive it. If you have any questions, please ask your health care provider. If you decide not to have this information shared with MIIC, please call 1-800-657-3970.

Agreement

I have read or had explained to me the Vaccine Information Statement.
Click here for information:"Influenza Injectable **What You Need to Know**." I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccination be given to me or to the person named above for whom I am authorized to make this request.

Type/Sign Name of Client or Legal Guardian: _____ Date: _____

No	Yes		
☐	☐	1.	Are you sick today? (Fever of 100.5 or higher on the day of the clinic)
☐	☐	2.	Have you ever had Guillain-Barre Syndrome (a paralysis) within 6 weeks of an influenza vaccination?
☐	☐	3.	Does the person to be vaccinated have an allergy to a component of the vaccine?
☐	☐	4.	Have you ever had a reaction to a dose of flu vaccine that needed immediate medical attention?

Please note: If sending Electronically, you will receive a confirmation email.

SUBMIT

FOR CLINIC USE ONLY	
Vaccine type	**INFLUENZA**
Manufacturer	
Lot number	
Site of injection/route	**IM-LD IM-RD**

FOR CLINIC USE ONLY	Date/VIS Given	Current VIS Dates
		Influenza 08/15/2019

Flu Mist (Nasal) Administration Form

Public Health
Prevent. Promote. Protect.

Complete this form if you are ages 2 through 49 years: The following questions will help us determine if there is any reason we should not give you or your child live attenuated intranasal influenza vaccine (FLU MIST). If you answer "YES" to any question, please fill out injectable form.

Enter Contact Information, click submit on bottom of page or print form and bring it to the clinic.

Contact Information - person being vaccinated

Last Name | First Name | Middle I | Gender ☐ Male ☐ Female | Date of Birth

Street Address | City | State | Zip Code | Phone Number

Email Address

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Agreement: I have read or had explained to me the Vaccine Information Statement Click here for information:"Influenza Flu Mist **What You Need to Know**." I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccination be given to me or to the person named above for whom I am authorized to make this request.

Type/Sign Name of Client or Legal Guardian: _____ Date: _____

No	Yes	
☐	☐	Is the person to be vaccinated sick today?
☐	☐	Does the person to be vaccinated have an allergy to component of the influenza vaccine?
☐	☐	Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?
☐	☐	Is the person to be vaccinated younger than age 2 years or older than age 49 years?
☐	☐	Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, or metabolic disease (diabetes)?
☐	☐	If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma?
☐	☐	Does the person to be vaccinated have a cochlear implant, spinal fluid leak, or no spleen, have cancer, leukemia, HIV/AIDS, or any other immune system problem; In the past 3 months, have they taken medications that affect the immune system (prednisone or other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or anticancer drugs); or have they had radiation treatments?
☐	☐	Is the person to be vaccinated receiving or has recently received influenza antiviral medications?
☐	☐	Is the person to be vaccinated a child or teen age 6 months through 17 years and receiving aspirin or salicylate-containing medicine?
☐	☐	Is the person to be vaccinated pregnant or could she become pregnant within the next month?
☐	☐	Has the person to be vaccinated ever had Guillain-Barre syndrome?
☐	☐	Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (an isolation room of a bone marrow transplant unit)?
☐	☐	Has the person to be vaccinated received any other vaccinations in the past 4 weeks?

Please note: If sending Electronically, you will receive a confirmation email.

SUBMIT

FOR CLINIC USE ONLY	Date/VIS Given	Current VIS Dates
		Flu Mist 8/15/19
Vaccine Type: Flu Mist	Manufacturer	Lot Number