LEADWELL™
CORPORATE HEALTH & WELLNESS PROGRAM

Flu Shot Registration Form

Note: Please use full name as stated on driver's license/state ID

Full Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

City of Springfield covered members under the COS health plan:

- ☐ Employee
- ☐ Dependent
- ☐ Retiree
- ☐ Retiree Dependent

Email Address: _____

Primary Care Physician: _____

Employer: _____

Status:

- ☐ Full-Time
- ☐ Part-Time
- ☐ Other: _____

Emergency Contact: _____ Phone number: _____

HSHS Medical Group

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Influenza Form

Patient: Please complete shaded portion and signature line.

Do you currently have an illness or fever?	YES	NO
Have you ever had an allergic reaction to the Influenza vaccine?	YES	NO
Do you have a history of Guillain-Barre Syndrome?	YES	NO

Print Patient Name	Patient Date of Birth	Patient Age

Vaccine Information

Manufacturer: _____Sanofi_____

Expiration Date: _____

NDC#: _____

Lot#: _____

Administration Site (circle one): Left Arm / Right Arm

Administered By: _____

Verified By: _____

Administration Date: _____

Dosing: Check the Appropriate Box Below:

- ○ 5yr-64yrs: FluZone Regular Dose (0.5mL)
- ○ 65 yrs or older: FluZone High Dose (0.5mL)

CONSENT FOR IMMUNIZATION/INJECTION

I consent to accept the immunization(s)/injection(s) indicated above. If applicable, I have received, read and understand the Vaccine Information Statement (VIS) produced by the CDC describing contraindications and possible side effects after administration. For allergy/immunotherapy medications, I understand I must remain under observation at the office for 30 minutes and if I cannot wait 30 minutes, I understand I should not receive my allergy/immunotherapy medication. I understand that if I leave before the end of the 30 minute observation period, I may not be permitted to receive my Allergy/Immunotherapy medication at HSHS Medical Group in the future. I assume responsibility for accepting the immunization(s)/injection(s) indicated above and will not hold HSHS Medical Group liable for any adverse reactions or complications resulting from my vaccination.

Printed Name of Patient or Guardian _____ Signature of Patient or Guardian _____ Date _____

HSHS Medical Group