



507 N. Nanum Street, Suite 102  
 Ellensburg, WA 98926  
 T: 509.962.7515 F: 509.962.7581  
 www.co.kittitas.wa.us/health/

**Staff only**  
 6m-18  
 Year 21: \_\_\_\_\_

**Staff only**  
 Check-in Hour: \_\_\_\_\_  
 Entered in WAIS:  \_\_\_\_\_  
 Initial

### Influenza Vaccine Intake Form (6 Month +)

Name: (Last)	(First)	(Middle Initial)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Age:
--------------	---------	------------------	---	------

Race: (mark all that apply):  Native American or Alaskan  Asian  White  Black or African American  
 Hispanic/Latino  Other: \_\_\_\_\_

Mailing Address:	City:	Zip:	Home Phone:	Birth date:
------------------	-------	------	-------------	-------------

**Child Insurance Information**

Does the child have health insurance?  Yes  No (if yes, select below)

Uninsured  Underinsured  Medicaid  American Indian/Alaska Native Child  CHIP  Insured Private \_\_\_\_\_

	YES	NO	UNSURE
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have a severe allergy to eggs or to a vaccine component?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a severe reaction, including Guillain-Barre Syndrome, after receiving a flu vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. For children, have <b>fewer than four weeks</b> passed since your child's last flu shot? <input type="checkbox"/> Check this box if this is your child's first flu shot in his or her life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

➔ I have read or had explained to me the information on the Vaccine Information Statement (VIS) about the influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or to the person named for whom I am authorized to make this request.

➔ I have received the Notice of Privacy Practices and consent to the disclosure of this protected health care information for treatment, payment and health care operations.

I am  the patient  the child's Parent/Guardian (please print name) \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

<i>Staff Only</i>	Manufac.	Lot # Expiration	Dose	Site	Route	Required Name/Signatures
<input type="checkbox"/> Adult Flu	SEQIRUS	ADU-409411 06/30/2026	0.5mL	LA RA LL RL	<input checked="" type="checkbox"/> IM	_____ Signature of Administrator (Signature & Print Name)
<input type="checkbox"/> Child Flu	SEQIRUS	406989 05/06/2026	0.5mL			_____ Co-Signer (Signature & Print Name)

FD	Version: 5	Supersedes: 3	Date Adopted: 10/7/2024	Modified/Created By: Kate Johnson 10/16/25	Approval By: Chelsey Loeffers
----	------------	---------------	----------------------------	---	-------------------------------