**MyCare Health Center**

18 Market Street, Suite C, Mt. Clemens, MI 48043 P: 586.783.2222 F: 586.783.6280
6900 E. Ten Mile Road, Center Line, MI 48015 P: 586.756.7777 F: 586.756.7788
43740 Groesbeck Highway, Clinton Township, MI 48036 P: 586.783.2222 F: 586.783.6280

www.mycarehealthcenter.org

# Pre-Immunization Questionnaire

| Patient name | Date of birth (DOB) | Gender<br>Male Female |
|---|---|---|
| Address, City, State, Zip | Home phone | Cell phone |

| Emergency contact | Emergency contact phone |
|---|---|

| Question | | |
|---|---|---|
| 1. Are you allergic to eggs or egg products? | Yes | No |
| 2. Are you allergic to Thimerisol? (a preservative in some vaccines) | Yes | No |
| 3. Are you allergic to latex? | Yes | No |
| 4. Have you ever had a serious vaccine reaction after receiving a vaccine?<br>If yes, please describe: | Yes | No |
| 5. Are you sick today or have you been sick within the past 24 hours?<br>If yes, please describe: | Yes | No |
| 6. Have you ever had Guillian-Barre Syndrome?<br>(This is a temporary severe muscle weakness/paralytic disease.) | Yes | No |

I have answered "no" to questions 1-6. I have read, or have had explained to me, 2012 Injectable Influenza Vaccine Information Statement and/or the 2012 Intranasal Vaccine Information Statement. I understand the benefits and risks of the vaccine.

- ☐ Injectable Vaccine

The vaccine check above should be given to the person named above for whom I am authorized to make this request. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

________________________________________ ____________________

Signed (patient or parent, if minor) Date

**For administrative use only:**

| Vaccine | Date Given | Route | Manufacturer | Lot No. | Signature of Vaccine Administration |
|---|---|---|---|---|---|
| | | ☐ IM R L<br>☐ Subcutaneous | | **Expiration:** | |

Signature and title of vaccine administrator: ______________________________ Date: ____________