Cheddar Medical Centre

2020 Flu Form

Please complete in BLOCK CAPITALS

Name: …… **Age:** …….

Ethnicity*: ……..

You cannot have an influenza vaccination if you have a fever. Do you feel feverish today? **Yes/No**

Have you had an influenza vaccination before? **Yes/No**

Do you have an egg allergy? **Yes/No**

Have you ever had an allergic reaction to a Vaccination? **Yes/No**

Complete this form and bring it to your appointment.

For Clinician to complete:

Vaccine Given (circle):

Left Arm **Right Arm**

Initials:……..