



HAMILTON COUNTY PUBLIC HEALTH

250 William Howard Taft Road, 2nd Floor
Cincinnati, OH 45219 • 513.946.7800
hamiltoncountyhealth.org

Name of person receiving the vaccine _____

Date of birth of person receiving the vaccine _____

Please circle yes or no to each of the following questions for the person receiving the vaccine. If you answer YES to any of the first three questions please contact our office at 946-7903.

1. Had a serious reaction (trouble breathing, prolonged rash, wheezing etc.) to a previous dose of flu vaccine? Yes No

2. Had Guillain-Barre Syndrome (temporary severe muscle weakness) within 6 weeks after receiving flu vaccine. Yes No

3. Moderate or severe allergy to eggs, MSG and/or gentamycin Yes No

Under 2 years of age Yes No

Over 50 years of age Yes No

Pregnant Yes No

Weakened immune system Yes No

– Long term health problem Yes No

– Heart disease Yes No

– Lung disease Yes No

– Asthma Yes No

– Kidney or liver disease Yes No

– Metabolic disease such as diabetes Yes No

– Anemia or other blood disorder Yes No

– Muscle or nerve disorder that lead to breathing or swallowing problems Yes No

Caring for person who requires care in a protected environment, such as a bone marrow transplant unit Yes No

Severely ill at this time Yes No

Received any live vaccine within the last 30 days Yes No