Southern Coos Hospital Clinic for *Influenza* and/or COVID-19 Vaccines

I have filled out a separate vaccine screening form. I consent to receive an INFLUENZA and/or COVID-19 Vaccine, and at this time all my questions or concerns have been answered.

I understand that this is a drive through event, and I will monitor myself for signs/symptoms of ANAPHYLAXIS (Hives, Swelling in Face, Shortness of Breath) and will seek medical attention (call 911 or go to the Emergency Room) right away if I experience these symptoms. It is recommended that you wait on site to be monitored for unexpected severe vaccine reactions for a minimum of 15 minutes after receiving the vaccination.

Recipient's Printed Name _____Signature_____

DOB _____ Home/Cell Phone _____

Mailing Address _____Physical Address _____

Email Address _____

****

(Information below is to be filled out by the NURSE) *DATE* _____

INJECTION INFORMATION:

Sanofi-Pasteur Fluzone 2024-2025 Formula Preservative Free *(Circle One Below)*	***COVID-19 Vaccination Fall 2025***
Fluzone 0.5 ml OR High Dose Fluzone 0.7 ml (**Over Age 65**)	MODERNA SPIKEVAX
Lot # _____ Exp. Date_____ VIS DATE: 1/31/2025 VIS GIVEN: YES Route: IM Injection Site: Right Deltoid OR Left Deltoid	Lot # _____ Exp. Date_____ VIS DATE: 1/31/2025 VIS GIVEN: YES Route: IM Injection Site: Right Deltoid OR Left Deltoid

Nurse Name Printed _____Nurse Signature _____

Southern Coos Hospital and Health Center
900 11th Street SE
Bandon, Oregon 97411