N.Y. HOTEL URGENT MEDICAL SERVICES, P.C.
RONALD A. PRIMAS, M.D., F.A.C.P., F.A.C.P.M.
952 FIFTH AVENUE SUITE 1D
NEW YORK, NEW YORK 10021
www.TravelMD.com
DrPrimas@travelMD.com
(212) 737-1212

INFLUENZA IMMUNIZATION AUTHORIZATION FORM – 2020/2021

Please complete the following if you wish to have a Flu shot.

1. Have you ever had an allergic reaction to eggs, egg products, chicken, or chicken feathers?
   Yes ____ No ____

2. Have you ever had an allergic reaction to Flu shots in the past?
   Yes ____ No ____

3. Do you now have an acute respiratory disease, bad cold, flu or other infection?
   Yes ____ No ____

If the answer to any of the questions is "Yes" then you will not be eligible to have an Influenza immunization at this time.

I wish to have the influenza vaccination.

Date ____________________

Signature of Patient ____________________________________

____
(Please print your name clearly)

For office use only

Influenza 2020-2021

Dose, Site and Route of Administration	Exp.	Manufacturer	Lot#	Name, Title of Person Giving Vaccine