Immunization Clinic Hours are from 7:30AM to 2:00PM Monday thru Friday. The clinic is closed on the 2nd Friday of each month. For ease of access, APPOINTMENTS ARE NOT AVAILABLE and services are provided on a walk-in, first come, first served basis.

832 West Central Blvd. Orange.FLHealth.gov Ph. 407-836-2502 Fax: 407-836-2595

ADULT

☐SR ☐CP ☐IOS ☐SS ☐DL ☐GC ‖ID
☐NSR ☐CNP ☐BC ☐PP ☐SI ☐MI ‖COLL

Last Name : ______________________________
First Name: ______________________________
Middle Name: __________________ **Race:** ______
Birthdate: ______-_____-______**Female or Male:** ____

☐SR ☐CP ☐IOS ☐SS ☐DL ☐GC ‖ID
☐NSR ☐CNP ☐BC ☐PP ☐SI ☐MI ‖COLL

Last Name : ______________________________
First Name: ______________________________
Middle Name: __________________ **Race:** ______
Birthdate: ______-______-______**Female or Male:** ____

Home Address: ___________________________ **Apt/Unit #** _______ **City:** ______________ **St:**______

Zip code: _________ **Cell Phone: (**_______**)** _______-________ **Home Phone: (**______**)** _______-________

RECEIPT FOR PAYMENT OF VACCINATIONS AND FORMS MUST BE PRESENTED PRIOR TO RECEIVING SERVICE

Signature ____ **Date:** ________/ ______/ ________

Entry Ticket #	Entry Ticket #
Q-Flow Ticket #	Qflow Ticket #

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Please CIRCLE Y for YES or N for No to the following questions about each adult

Adult's Name:

What **YEAR or AGE** did you have the Chicken Pox **DISEASE**?

Y	N	Are you sick today?
Y	N	Are you allergic to Eggs, Latex, Baker's Yeast or Gelatin?
Y	N	Would you like a **FLU** shot today?
Y	N	Do you have allergies to medications, food, a vaccine component, or latex?
Y	N	Have you ever had reactions to **Pertussis** (Whooping Cough) or other shots?
Y	N	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?
Y	N	In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?
Y	N	Do you have Cancer, Leukemia, HIV/AIDS or other immune system issues?
Y	N	Have you had your spleen removed?
Y	N	Have you had vaccines and/or a TB skin test in the last 4 weeks?
Y	N	In the **past year**, have you had a blood transfusion or been given blood products, immune (gamma) globulin or antiviral medications?
Y	N	Have you had a seizure or a brain or other nervous system problem?
Y	N	Have you had brain or other nervous system problems?
Y	N	If you are a female, are you pregnant or is there a chance that you could become pregnant during the next month?

Last menstrual cycle for : ________/________/________

IMM ID #:

Vaccines Administered

Adult's Name:

What **YEAR or AGE** did you have the Chicken Pox **DISEASE**?

Y	N	Are you sick today?
Y	N	Are you allergic to Eggs, Latex, Baker's Yeast or Gelatin?
Y	N	Would you like a **FLU** shot today?
Y	N	Do you have allergies to medications, food, a vaccine component, or latex?
Y	N	Have you ever had reactions to **Pertussis** (Whooping Cough) or other shots?
Y	N	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?
Y	N	In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?
Y	N	Do you have Cancer, Leukemia, HIV/AIDS or other immune system issues?
Y	N	Have you had your spleen removed?
Y	N	Have you had vaccines and/or a TB skin test in the last 4 weeks?
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Y	N	Have you had a seizure or a brain or other nervous system problem?
Y	N	Have you had brain or other nervous system problems?
Y	N	If you are a female, are you pregnant or is there a chance that you could become pregnant during the next month?

Last menstrual cycle for : ________/________/________

IMM ID #:

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