Flu Vaccine Form

Patient Name: _____ Date: _____ F: ☐ M: ☐

DOB: _____ Age: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I, the undersigned, have read or had explained to me the vaccine information sheet (VIS). I understand the risks and benefits associated with the influenza vaccine and have had any questions satisfactorily answered. I voluntarily request that the vaccine be given to me or for the aforementioned person for whom I am authorized to make this request.

_____ _____

Signature **Date**

Screening Questions

Are you currently ill or do you have a fever?	**yes**		**no**		**unknown**	
Have you received the vaccine before?	**yes**		**no**		**unknown**	
Have you had a reaction to the vaccine before?	**yes**		**no**		**unknown**	
Have you been sick in the last 2 weeks?	**yes**		**no**		**unknown**	
Are you allergic to egg or dairy products?	**yes**		**no**		**unknown**	
Are you allergic to thimerosal?	**yes**		**no**		**unknown**	
Are you pregnant?	**yes**		**no**		**unknown**	
Are you a Health Care Worker?	**yes**		**no**		**unknown**	
Have you ever had Guillain-Barre syndrome?	**yes**		**no**		**unknown**	
Do you have a blood-clotting disorder?	**yes**		**no**		**unknown**	
Are you taking blood thinning medication?	**yes**		**no**		**unknown**	

FOR OFFICE USE ONLY

Date given: _____ Manufacturer & lot #: _____

Exp. Date: _____ Site: RT ☐ LT ☐ RD ☐ RT ☐

Route: ____IM____ Administered by: _____