Flu Vaccine Form

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

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 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 Questionnaire						
Are you currently ill or do you have a fever?		Yes		No		Unknown
Have you received the flu 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 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 ☐ LD ☐
Route:	Administered By:

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