
Name of person receiving vaccine (please print)____/____/____
DOB_____
Age_____
Street Address_____
City_____
State_____
Zip_____
Insurance***If patient is receiving the REGULAR VACCINE please complete:****Have you ever had any of the following:***Yes No**

- Life-threatening reaction to eggs, such as trouble breathing
- Life-threatening reaction to a previous flu shot, such as trouble breathing
- Guillain-Barre` Syndrome within 6 weeks of receiving a flu shot
- Bone Marrow transplant within the past 6 months
- Anaphylactic latex allergy
- Previous immunization this flu season

If you answered yes to any of the above, you may not receive a flu shot this year.

- Do you currently have a high fever?
(If so, you should wait until you have recovered before receiving a flu vaccine)

I have truthfully answered all of the questions on this form. I have also received a copy of the Vaccine Information Statement. My signature below indicates my permission for the vaccine to be administered to me.

Signature of person receiving vaccine or Parent/Guardian

- Influenza Vaccine, quadrivalent Influenza A subtype and B type, **0.5 mL, IM (6 months and older)**
- Flublock, (Egg Free)** Influenza Vaccine, quadrivalent (RIV4), derived from recombinant DNA, **0.5 mL (18 years and over)**
- High Dose** Influenza Vaccine quadrivalent Influenza A subtype and B type, trivalent formulation, **0.7 mL, IM (65 and over)**

Lot # _____

Manufacturer _____

Site _____

Date ____/____/____

Administered by: _____

Name, Clinical Title

DATE: _____