TriHealth Physician Partners

2024-2025 Influenza Immunization Questionnaire

_____ _____/_____/_____ _____

Name of person receiving vaccine (please print) DOB Age

_____

Street Address City State Zip

Insurance_____

If patient is receiving an* Influenza 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.)
□ □ Have you ever felt dizzy or faint before, during, or after a shot?
□ □ Do you currently feel anxious about receiving the shot today?

I have truthfully answered all 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

- **Fluzone** Influenza Vaccine, TRIvalent Influenza A subtype and B type virus,
  - **0.25mL or 0.5 mL, IM (6 months through 35 months per provider order)**
  - **0.5 mL, IM (36 months and older)**
- **Flublock (Egg Free)** Influenza Vaccine, TRIvalent Influenza A subtype and B type virus, recombinant HA proteins, **0.5 mL (18 years and over)**
- **High Dose** Influenza Vaccine TRIvalent Influenza A subtype and B type virus, **0.5 mL, IM (65 and over**)

Lot # _____ Manufacturer _____

Site _____ Date _____/_____/_____

Administered by: _____

Name, Clinical Title

DATE:_____