
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 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 antigens, **0.5 mL (9 years and older)**
- **High Dose** Influenza Vaccine TRivalent Influenza A subtype and B type virus, **0.5 mL, IM (65 and older)**

Lot # _____

Manufacturer _____

Site _____

Date ____/____/____

Administered by: _____

Name, Clinical Title

DATE: _____