

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 Questionnaire

Are you currently ill or do you have a fever?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown
Have you received the vaccine before?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown
Have you had a reaction to the vaccine before?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown
Have you been sick in the last 2 weeks?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown
Are you allergic to egg or dairy products?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown
Are you allergic to thimerosal?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown
Are you pregnant?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown
Are you a Health Care worker?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown
Have you ever had Guillain-Barre syndrome?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown
Do you have a blood-clotting disorder?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown
Are you taking blood-thinning medication?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown

For Office Use Only

Date Given: _____	Manufacturer & Lot #: _____
Exp. Date: _____	Site: RT <input type="checkbox"/> LT <input type="checkbox"/> RD <input type="checkbox"/> LD <input type="checkbox"/>
Route: _____	Administered By: _____