Flu Vaccination Form

Patient Name:_____ DOB:_____

Phone:_____ Email Address:_____

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?		Yes		No	Unknown	
Have you had a reaction to the vaccine before?		Yes		No	Unknown	
Have you been sick in the last week?		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	
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: IM Sub Q Administered By_____

Company Name_____ R-Health Member Yes No

Insurance Type_____