

2011 – 2012 INFLUENZA VACCINE ADMINISTRATION RECORD

LAST NAME	FIRST NAME	MI	Date of Birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Number & Street)	City	State	Zip	Phone	

Is the person receiving the vaccine sick today? Yes No

Does the person receiving the vaccination have any serious or chronic illness? If yes, please list _____ Yes No

Has the person receiving the vaccination had any allergies to medications, food (eggs), Latex, or any vaccines? Yes No

Is the person receiving the vaccination taking any medications at this time? If yes, please list _____ Yes No

Has the person receiving the vaccination ever had Guillain-Barre syndrome, received blood, blood products, or gamma globulin in the past 6 months? Yes No

Has the person receiving the vaccination received any other vaccines or antivirals in the last 30 days? Yes No

Is the person receiving the vaccine pregnant? Yes No

I have read the Vaccine Information Statement or have had explained to me the information about the vaccinations to be given. I have had the chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks involved with receiving vaccinations and ask that vaccine(s) be given to me or to the person named on the top of this sheet for who I am authorized to make the request. I authorize the release of medical or other information necessary to process the claim.

By signing this form I also acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature of person receiving vaccine or person authorized to make the request (parent / guardian):

X _____ Date: _____

HEALTH DEPARTMENT USE ONLY

<u>Date</u>	<u>Lot #</u>	<u>Manufacturer</u>	<u>Trade Name</u>	<u>VIS Date</u> 7/26/11
	UT4119AA	Sanofi	Fluzone	
<u>Route</u> IM IN	UH456AA UH476AD			
	501105P YK2015	Med Immune	Flumist	
<u>Site</u> RD LD RT LT IN		GSK	Flu LAVAL	

Vaccinator: _____