

Flu Shot Visit 2020/2021

Patient Name: _____ DATE OF BIRTH: _____ AGE: _____

Insurance Company: _____

Ins. ID (required if new): _____

Does the above listed Patient have...?

- Yes No A serious allergy to eggs or egg products?
- Yes No A fever over 101°?
- Yes No A past severe reaction to the flu shot?
- Yes No A history of Guillain Barre Syndrome?
- Yes No Taking aspirin regimen prescribed by a doctor?
- Yes No Contact with a transplant patient?
- Yes No Asthma requiring medicine in last year?
- Yes No Chronic Illness such as: heart disease, diabetes, kidney disease, immune system, or hemoglobin disorder,
Other: _____?
- Yes No Received the MMR or Chicken Pox vaccine in the last month?

I have read, and I understand the information given to me, including the Vaccine Information Statement (VIS). I have had a chance to ask questions, which were answered to my satisfaction. I believe that I understand the benefits and risks of taking the flu vaccine, and I request that the vaccine be given to me or to the person named for whom I am authorized to sign.

Signature: _____

Date: _____

FOR OFFICE USE:

- Flulaval QIV PF Flumist QIV PF
0.5 ml (90686) (90672)

Administered By: _____

Administered: LA RA LT RT Intranasal Lot #: _____ Exp: _____

VFC Given: YES NO