GLACIAL RIDGE
HEALTH SYSTEM

# INFLUENZA VACCINE ADMINISTRATION FORM

Information on this form will be used to document authorization for receipt of vaccine. Information may be shared with your health care provider, your insurance company, and Medicare. Information collected on this form is voluntary.

## PATIENT DEMOGRAPHIC INFORMATION

**Name:** _____ **Date of Birth:** _____
**Last** **First** **Mi**

**Address:** _____
**Phone:** _____

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|---|---|---|---|
| **Flu vaccination screening questions:** | 1. Are you sick today? (minor illness is not a contraindication to vaccination) | ☐ Yes | ☐ No |
| | 2. Do you have a life-threatening allergy to a vaccine component? | ☐ Yes | ☐ No |
| | 3. Do you have an egg allergy? | ☐ Yes | ☐ No |
| | 4. Have you had a serious reaction to an influenza vaccine in the past? | ☐ Yes | ☐ No |
| | 5. Have you ever had Guillain-Barré syndrome? | ☐ Yes | ☐ No |
| **LAIV eligibility: ONLY COMPLETE THIS SECTION IF FLUMIST DESIRED.**<br><br>**A "YES" ANSWER IN THIS SECTION MEANS YOU SHOULD NOT HAVE LIVE INFLUENZA VACCINATION SUCH AS FLUMIST.**<br><br>**(YOU CAN STILL HAVE THE FLU SHOT.)** | 1. Are you 50 years of age or older OR LESS THAN 2 YEARS OLD? | ☐ Yes | ☐ No |
| | 2. Do you have a chronic health condition that includes any of the following:<br>*Heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes); anemia or other blood disorder; or a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?* | ☐ Yes | ☐ No |
| | 3. Are you pregnant or planning to become pregnant in the next month? | ☐ Yes | ☐ No |
| | 4. Do you have close contact with patients hospitalized for bone marrow transplants? | ☐ Yes | ☐ No |
| | 5. Are you taking daily antiviral medications or, if less than 18, daily aspirin? | ☐ Yes | ☐ No |
| | 6. Have you received MMR, Varicella, MMRV, yellow fever vaccine, or any other vaccines in the last 4 weeks? | ☐ Yes | ☐ No |

I have been given a copy of Vaccine Information Statement for Influenza. I have had an opportunity to ask questions and have them answered to my satisfaction. My signature indicates consent for the influenza vaccination.

_____ _____
**Signature of the person to receive the vaccine** **Date**

| | | |
|---|---|---|
| BRAND:<br>LOT:<br>EXP: DOSE: mL<br>IM: LT / RT ARM<br>DATE:<br>Nurse Administering: | FLUZONE – SANOFI **NoPres** - Prefilled<br>LOT:<br>EXP.: DOSE: 0.5mL<br>IM : LT / RT ARM<br>DATE:<br>Nurse Administering: | FLUZONE (**HIGH DOSE**) **NoPres** – SANOFI (65 yrs +)<br>LOT:<br>EXP.: DOSE: 0.7mL<br>IM : LT / RT ARM<br>DATE:<br>Nurse Administering: |