2017 Influenza Vaccination Administration Record

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)		
LAST:	**FIRST:**	**MIDDLE INITIAL:**
PREFERRED PHONE #:		
DATE OF BIRTH:		

Please answer the four questions and sign below

For adult patients to be vaccinated: The following questions will help us determine if there is any reason we should not give you the influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	YES	NO	DON'T KNOW
Are you sick today (fever, nausea, etc.)?	☐	☐	☐
Do you have an allergy to eggs?	☐	☐	☐
Have you ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
Have you ever had Guillain-Barré syndrome?	☐	☐	☐

I have read or have had explained to me the information in the vaccine information statement about influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risk of influenza vaccine and ask that the vaccine be given to me:

Please Sign Here: ______________________________ Date: ____/____/2017

Do Not Write Below This Line

Date Vaccine Administered	/ /2017
Vaccine Name & Manufacturer	Sanofi Pasteur (Fluzone QIV)
Vaccine Lot Number & Expiration Date	
Site of Injection	L Arm R Arm
Strength of Vaccine Given	0.5ml/ IM
Signature of Administrator: Matthew D. Harman, PharmD, MPH	