INFLUENZA VACCINE 2024-2025

Circle One: **Faculty/Staff** **Student** **Visitor**

Information about the person to receive the vaccine *(Print in blue or black ink)*			
Name: Last, First, MI	**Date of Birth:**		**Age:**
University ID #		**Telephone:**	
Address (Street):	**City:**	**State:**	**Zip code:**
Signature of person to receive the vaccine or person authorized to make the request. (*Parent or guardian if under 18 years of age.)* **X** _____ **Date:** _____			

Please answer the following questions, explain if the answer is "Yes"

1. Are you sick today, or have a fever?
NO □ **YES** □ _____

2. Have you ever felt dizzy or faint before, during or after a shot?
NO □ **YES** □ _____

3. Do you have allergies to medications, food, eggs/egg products, a vaccine component, latex, or Thimerosal (preservative)?
NO □ **YES** □ _____

6. Have you ever had a serious reaction after receiving a vaccine?
NO □ **YES** □ _____

7. Have you ever had Guillain-Barre Syndrome?
NO □ **YES** □ _____

8. Have you had any disorder in the last month that caused brain or nerve damage such as stroke or convulsion?
NO □ **YES** □ _____

9. Is there a possibility of pregnancy?
NO □ **YES** □ _____

10. Have you already received a flu vaccine this flu season (October – May)?
NO □ **YES** □ _____

11. Are you anxious about getting a shot today?
NO □ **YES** □ _____

Administration Site (Circle one): **Left Arm** **Right Arm**

Vaccine (Circle one): **Fluarix** **High Dose FLuzone** **Flublok**

Lot#: _____

Exp. Date: _____

Revised 06.2024