INFLUENZA VACCINE 2026-2027

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:**	
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:_____			

Question	**Response**		
1. Are you sick today?	Yes	No	Don't know
2. Do you have allergies to medications, food, a vaccine component, or latex?	Yes	No	Don't know
3. Have you ever had a serious reaction after receiving a vaccine?	Yes	No	Don't know
4. Have you had a seizure or a brain or other nervous system problem, such as Guillain-Barre Syndrome?	Yes	No	Don't know
5. Have you ever felt dizzy or faint before, during, or after a shot?	Yes	No	Don't know
6. Are you anxious about getting a shot today?	Yes	No	Don't know
7. Have you already received a flu vaccine this flu season (October - May)?	Yes	No	Don't know
8. Patient has been informed and acknowledges he/she is responsible for any fees not covered by insurance.	Yes	No	Don't know

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For UHC Staff Only

Administration Site (Circle one): Left Arm Right Arm

Vaccine (Circle one): Fluzone Fluzone HD Flucelvax

Lot #:_____ **Expiration date:**_____