



INFLUENZA VACCINE 2023-2024



Circle One:

Faculty/Staff

Student

Visitor

Information about the person to receive the vaccine <i>(Print in blue or black ink)</i>			
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. <i>(Parent or guardian if under 18 years of age.)</i>			
X _____		Date: _____	

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

1. Are you sick today or do you have a fever?

NO YES _____

2. Have you ever felt dizzy or faint before, during or after a shot?

NO YES _____

3. Are you allergic to eggs or egg products?

NO YES _____

4. Are you allergic to any medications or Thimerosal (preservative)?

NO YES _____

5. Are you sensitive to/allergic to latex?

NO YES _____

6. Have you ever had an adverse vaccine reaction?

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. Have you received the MonkeyPox vaccine in the last 4 weeks (e.g., JYNNEOS or ACAM2000)?
(If Yes, administer in a different anatomical site).

NO YES If Yes, which arm: _____

Flu Shot Administered (Site): _____

Vaccine: _____ **Lot#** _____

Exp. Date: _____