



INFLUENZA VACCINE 2023-2024



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"

- Are you sick today?
NO ☐ YES ☐ _____
- Do you have a fever?
NO ☐ YES ☐ _____
- Are you allergic to eggs or egg products?
NO ☐ YES ☐ _____
- Are you allergic to any medications or Thimerosal (preservative)?
NO ☐ YES ☐ _____
- Are you sensitive to/allergic to latex?
NO ☐ YES ☐ _____
- Have you ever had an adverse vaccine reaction?
NO ☐ YES ☐ _____
- Have you ever had Guillain-Barre Syndrome?
NO ☐ YES ☐ _____
- Have you had any disorder in the last month that caused brain or nerve damage such as stroke or convulsion?
NO ☐ YES ☐ _____
- Is there a possibility of pregnancy?
NO ☐ YES ☐ _____
- Have you already received a flu vaccine this flu season (October – May)?
NO ☐ YES ☐ _____
- 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: _____