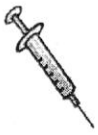
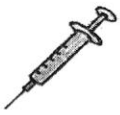


INFLUENZA VACCINE 2020-2021



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?
   NO □ **YES** □
2. Do you have a fever?
   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 a 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** □_____

Lot # _____ **Exp. Date** _____