2024 Influenza Vaccination Authorization

Name (print): ___________________________Maiden Name (if applicable): ______________

Date of Birth: _________________ Phone Number: __________________ Gender: M F

Permanent Address: ____

________________________________ ________________ _________________
City State Zip

If covered under someone else's insurance please provide
Insurer's Name: ________________________ Insurer's Date of Birth: ________________
Your Relationship to Insurer i.e. mother, father, husband, etc.: _____________________

Answer the following questions:

1. Do you have a severe egg allergy or allergy to Thimerosal? Yes____ No____
2. Have you ever had a severe reaction to a flu shot? Yes____ No____
3. Are you now suffering from severe asthma, illness, cold or fever? Yes____ No____
4. Have you ever developed Guillain-Barre syndrome within six weeks of a previous dose of flu vaccine? Yes____ No____

I have read the information about influenza and the influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and request that the vaccine be given to me.

I understand I may experience mild soreness, redness or swelling at the injection site, fever, and/or muscle aches for 1 or 2 days, or I may experience no symptoms.

Signature: ____ Date: _______________
Self or Parent/Guardian (if under age 18 years)

Vaccinated by: _________________________ Lot # _____Exp_____Manufacturer_____
(or place vaccine sticker)
Supervisor: _____________________________ Date: ______________________________

Site of Injection: RD___LD___RT___LT___ 2nd dose needed: Yes_____No_____

Revised 8/28/24