2021 Influenza Vaccination Authorization

Name (print): ______________________________Maiden Name (if applicable): _______________

Date of Birth: ___________________ Phone Number: ____________________ Gender: M F

Permanent Address: ____

____________________________________ __________________ ___________________
City State Zip

Answer the following questions:

1. Do you have a severe egg allergy? 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_____