



2023 Influenza Vaccination Authorization

Name (print): _____ Maiden Name (if applicable): _____

Date of Birth: _____ Phone Number: _____ Gender: M F

Permanent Address: _____

_____ City _____ State _____ Zip _____

Insurer's Date of Birth (if covered under someone else's insurance): _____

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 ___