2025 Influenza Vaccination Authorization

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

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

Permanent Address: _____

_____ _____ _____
City State Zip

Students - 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 & the influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits & risks of the influenza vaccine & 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: _____ Date: _____

Supervisor: _____ Lot # _____Exp_____Manufacturer____

Site of Injection: RD____LD____RT____LT____ 2nd dose needed: Yes_____No_____