



Influenza Vaccine Administration Record

First Name _____ Last Name _____

Date of birth ___/___/_____ Please Indicate Yes or No

Have you ever had any reaction to the flu vaccine in the past? Yes No

Do you have any allergies to eggs or vaccine components? Yes No

Have you recently been moderately or severely ill? Yes No

Have you ever been diagnosed with Guillain-Barré syndrome? Yes No

Comments

I have read and been given the Vaccine Information Statement (VIS) Inactivated Influenza Vaccine from the CDC dated 08/11/2009 and understand the benefits and risks associated with receiving the vaccine.

I consent to having the vaccine administered to me.

Signature of Patient/Parent or Authorized Representative Date

For Center Use

Influenza Vaccine Date ___/___/_____

Dose 0.5ml _____ Deltoid Administered By _____ (Initials)

Manufacturer _____ Lot Number _____

Expiration ___/___/_____