FAMILY PRACTICE OF UPPER DUBLIN
INFLUENZA VACCINATION FORM
2020-2021

Section 1: Contact Information

PATIENT'S NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** **Month_________ Day________ Year __________**
ADDRESS			**DAYTIME PHONE NUMBER:**
CITY	**STATE**	**ZIP**	

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if you can get the seasonal influenza vaccine. If you answer "NO" to all four of the following questions, you can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, you may not be able to get the seasonal influenza vaccine, however we will discuss your options.

Please mark YES or No for each question below	**YES**	**NO**
1. Do you have a serious allergy to eggs?	☐	☐
2. Do you have any other serious allergies? Please list: ____	☐	☐
3. Have you ever had an anaphylactic reaction following a previous dose of the flu vaccine?	☐	☐
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐

Section 3: Consent

CONSENT FOR VACCINATION:

I have read or had explained to me the Vaccine Information Statement for the seasonal influenza vaccine. I have had the chance to ask questions which were answered to my satisfaction, and I understand the risks and benefits of the vaccination as described.

☐ **I GIVE CONSENT** to FAMILY PRACTICE OF UPPER DUBLIN and its staff to be vaccinated with this vaccine.

☐ **I DO NOT WANT THE VACCINATION AT THIS TIME**.

☐ **I HAVE RECEIVED THE VACCINATION** at the following: **Location:** __________________________ ____________________________________. **Date:** ______________.

Signature of Patient/Legal Guardian: ____Date: ____________

Witness Signature: ____Date:_____________

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	**Route**	**Administration Site**	**Date Dose Administered**	**Lot Number**	**Date on VIS**
Influenza (fluzone) Influenza (flublok) High Dose Influenza	IM	☐ Left Deltoid ☐ Right Deltoid ☐ Left Thigh ☐ Right Thigh	/ /		
Name and Title of Vaccine Administrator:					