

SEMC – INFLUENZA VACCINE ADMINISTRATION RECORD 2021-2022

Information about the person to receive vaccine. Please Print

Last Name _____			First Name _____			MI _____		
Address _____				City _____		State _____		Zip _____
Date of Birth _____			Age _____		Phone Number: _____			
Family Physician: _____					Nurse Initials _____			
Allergies _____					Primary Clinic: _____			

Please Answer the Following Questions

1. Are you allergic to eggs or egg products? Yes _____ No _____
2. Are you allergic to Thimerosal (a preservative)? Yes _____ No _____
3. Have you ever had Guillain-Barre Syndrome? Yes _____ No _____
4. Have you been ill or had a fever within the last 48 hours? Yes _____ No _____
5. Have you had the flu shot before? Yes _____ No _____
 - A. If yes, did you have any reaction to the flu vaccine? Yes _____ No _____
 - B. If yes, what were the symptoms? _____
 - C. Symptoms occurred how many years ago? _____
7. If female, are you pregnant? Yes _____ No _____

If you have had recent chemotherapy, radiation therapy, or steroids (except inhaled), these conditions may decrease the effectiveness of the vaccine. However, unless you physician has told you different, flu vaccination is still encouraged.

I have read or have had explained to me the Vaccine Information Statement about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me.

Sleepy Eye Medical Center will keep this record.

Signature: _____ **Date:** _____

Administrative Use Only:		
Date Administered/VIS given: ____/____/____		Date of VIS: 8/6/2021
Lot#:	Mfg: CSL MED SKB NOV PMC PSC	CPT code: 90662: Fluzone High Dose greater than 65 years (PMC) 90682: FluBlok 18 years and older 90686: Fluarix-Quad 6 months and older (GSK) 90672: Flu Mist age 2-49 (MED) Other:
Route:	Site:	Name and title of vaccine administrator: