Influenza Vaccine Administration Record 2020-21

- ☐ **Bill insurance:** Make appointment, enter order
- ☐ **Cash pay/Walk-in:** No appointment, no order
- ☐ **MCR roster bill:** No appointment, no order

_____
Patient Name

PLACE PATIENT LABEL HERE

Name: _____ DOB: _____

Do you currently have a severe illness with a fever?	Yes ☐	No ☐
Do you have a serious allergy to eggs?	Yes ☐	No ☐
Have you ever had a serious allergic reaction or other problem after getting influenza vaccination?	Yes ☐	No ☐
Have you been diagnosed with Guillain-Barré syndrome (severe muscle weakness)?	Yes ☐	No ☐

I have read or have had explained to me the information about influenza and the influenza vaccine. I was given a copy of the current vaccine information sheet on influenza today, prior to my immunization. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I certify that the above information is correct to the best of my knowledge. Proof of vaccination for employees, retirees, contractors and volunteers will be forwarded to my UT Health East Texas primary care provider (if indicated) for continuity of care purposes.

_____ _____
Signature Date

FOR CLINIC/UNIT USE ONLY

Vaccine manufacturer: _____ Vaccine lot number: _____ Exp. date: _____

Injection date: _____ Injection time: _____

Site of injection: ☐ Right deltoid ☐ Left deltoid

Before administering a dose of vaccine, shake the prefilled syringe.

Product: _____Fluzone high dose - 65 years or older - 0.5 ml. IM or

Product:_____FluBLOK quadrivalent - 18 years and older - 0.5 ml. IM (egg free)

Product:_____Fluarix quadrivalent - 6 months and older - 0.5 ml IM or

Signature and title of vaccine administrator: _____

Revised: September 16, 2020

VIS date: August 15, 2019

UTHealth East Texas