Request for 2022/2023 Seasonal Influenza (Flu) Immunization (Quadrivalent & Trivalent Vaccine)

Full Name: ____________________________ DOB:______________ Male □ Female □ Undifferentiated □

Screening Questionnaire	**Yes**	**No**
Have you or anyone in your household been exposed to a potential or confirmed case of COVID-19, or being tested for COVID-19?	□	□
Do you or anyone in your household currently have any symptoms of a cold or flu, including: cough, shortness of breath, fever, runny nose, or sore throat?	□	□
Do you have a fever or have you been started on antibiotics in the last 24 hours?	□	□
Have you ever received the Flu Vaccine before? If the child is under 9 years of age, has the vaccine been given before? Date:__________	□	□
Have you ever had any reaction to the flu vaccine before?	□	□
Have you ever had a reaction to any vaccine before?	□	□
Are you allergic to eggs?	□	□
Are you allergic to any of the components of the Flu Vaccine? (Egg protein, sodium deoxycholate, ethanol, formaldehyde, sucrose, a-tocopheryl hydrogen succinate, polysorbate 80, thimersoal)	□	□
Do you have any other allergies?	□	□
Do you have trouble with your blood clotting or are you taking “blood thinner” medication?	□	□
Have you ever had Guillian-Barre Syndrome?	□	□
Are you having new or worsening problems with your neurological system?	□	□
Do you have any other health problems/concerns?	□	□
Do you have any questions you would like to ask?	□	□

I have read, or had explained to me, information about the influenza vaccine. I have had the opportunity to ask questions to have them answered to my satisfaction. I have answered the screening questions to the best of my ability. I understand the benefits and risks of taking the influenza vaccine. I hereby consent to have the influenza vaccine approved for use in 2022-2023 season administered to me, or to the dependent person named above.

Date:___________________ Signature __________________________ Self □ Parent □ Guardian □

Two doses of seasonal flu vaccine administered at least 4 weeks (28 days) apart are recommended for children under the age of 9 receiving the flu vaccine for the first time. They are then recommended to receive one dose of seasonal flu vaccine per season thereafter.

OFFICE USE ONLY: Signature & Designation: ____________________________________

Vaccine	**R**	**L**	**Quad**	**Deltoid**	**0.5ml IM**	**0.2ml to Nares**	**2nd Dose in 4 weeks**	**Lot #**
Fluzone Quadrivalent ≥ **6mth**								
Fluzone **(*High Dose*) ≥ 65 yrs**								
FluMist **2-17yrs old**								
Flucelvax > 2 years								
FluLaval Tetra ≥ **6mth**								

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