Ledge Light Health District
Seasonal Influenza Vaccine Administration Record (2020)

Please Print:

Last Name_____ **First Name**_____ **M.I.**_____

Address:_____ _____ _____ _____
Street **Town** **State** **Zip Code**

Phone_____ **Date of Birth**_____ **Age**___ **Sex:** ☐**Male** ☐**Female**

Have you ever had a flu shot before? Yes___ No__

Check vaccine receiving: ___Injectable (shot) or ___Flumist (nasal spray age 19-49 years only)

Please Answer The Following Questions:

☐ Yes	☐ No	Is person sick or does person have a fever?
☐ Yes	☐ No	Has person ever had a serious reaction to a flu shot?
☐ Yes	☐ No	Serious allergies to eggs, gelatin, thimerosal (a preservative), gentamicin or arginine?
☐ Yes	☐ No	Has person ever had Guillain-Barré Syndrome ((a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?

Flu Mist (nasal spray) Must Be Between 19 years and 49 years:

☐ Yes	☐ No	Have you received any vaccines (MMR, Varicella) in the past 4 weeks?
☐ Yes	☐ No	Do you have long-term health conditions (asthma, heart disease, diabetes, HIV/AID)
☐ Yes	☐ No	Are you pregnant?
☐ Yes	☐ No	Do you have a weakened immune system or live with someone who does?
☐ Yes	☐ No	Are you without a spleen or have a non-functioning one?
☐ Yes	☐ No	Do you have an active leak between the cerebrospinal fluid and the mouth, nose, ear, or other place within the skull?
☐ Yes	☐ No	Do you have cochlear implants?
☐ Yes	☐ No	Have you taken flu antiviral drugs within the past 48 hours?

I have read or had explained to me the information sheet (VIS 8/15/19) about seasonal influenza and the influenza vaccine. I have had a chance to ask questions and I understand the benefits and risks of the influenza vaccine. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

For participants who are minors (less than 18 years of age): I attest that I am the legal guardian of this minor and I have authority to provide consent for this vaccination.

Signature _____ ***Print Name*** _____ ***Date*** _____

For Clinic Use:

Dose: ☐0.5 ml injectable Vaccine Manufacturer: Sanofi Fluzone: Lot# Exp.6/30/21

Site: ☐RD ☐LD

☐ Flu Mist 0.2ml Vaccine Manufacturer & Lot #: Medimmune Flu Mist MH2203 EXP. 12/29/20

Administered by: Date: