Ledge Light Health District
Seasonal Influenza Vaccine Administration Record (2021)

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**__

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?

I have read or had explained to me the information sheet (VIS 8/6/21) 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.

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

For Clinic Use:

Dose: ☐0.5 ml injectable Vaccine Manufacturer: Lot#: Exp.

Exp Site: ☐RD ☐LD

Administered by: _____ Date:_____