ADULT—INFLUENZA VACCINE RECORD OF ADMINISTRATION & RECIPIENT SIGNATURE

I have been provided a copy of, and have read or had explained to me the information in the 2015-16 Influenza Vaccine Information Sheet dated 8/7/15. I have had a chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of the influenza vaccine, and ask that the vaccine be given to me.

PLEASE PRINT CLEARLY. (All information must be filled in completely.)

_____

(Last) *(First)* *(Middle)*

Any previous name or nickname used: _____

Date of Birth: _____ *Birth State* _____ *Age:* _____

Address: _____

City _____ *State* _____ *Zip Code* _____

County of Residence: _____ *Gender:* ___ *male* ___ *female*

Phone #: _____ *Alternate Phone #:* _____

Email _____

Race: (check one) __ *White* __ *African American* __ *American Indian* __ *Alaskan Native* __ *Asian/Pacific Islander* __ *Multiracial* __ *other* __ *unknown*

Physician: _____

Allergies: _____

Signature of person to receive vaccine* or *person authorized to give consent:

_____ *Date* _____

For Office Use Only

Clinic Location: AFF–ALC–BLC–COA–COL–DCHD–HC–LCC–LFF–SIEOC–UCB

(Lot # sticker) **Date Vaccinated:** _____

Site of Vaccination: Left Arm Right Arm Left Thigh Right Thigh

Vaccinator Signature & Title: _____

Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Adults

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Technical content reviewed by the Centers for Disease Control and Prevention

www.immunize.org/catg.d/p4065.pdf • Item#P4065 (10/12)