

Patient Name: _____

Grade _____

Date of Birth: _____

Chart Number _____

Date: _____

SFIS FLU CLINIC

CLINIC CODE 12

CHIEF COMPLAINT: 2019-2020 INACTIVATED INJECTABLE INFLUENZA VACCINATION

S: Need Influenza Immunization

O: Annual Flu Immunization

A: Potential for Spread of Communicable Disease and Loss of Work/School

SCREENING QUESTIONNAIRE:

Has the person to be vaccinated already received a flu vaccine this season?..... YES NO

Is the person being vaccinated allergic to eggs, gelatin, or Thimerosal (mercury – containing preservative used in vaccines)? YES NO

Has the person to be vaccinated ever had a serious reaction to the Influenza vaccine in the past? (Shortness of breath, hives, difficulty breathing, etc.)..... YES NO

Is the person to be vaccinated sick today? (Fever, chills, body aches, etc.) YES NO

Has the person to be vaccinated ever had Gullain-Barre Syndrome?..... YES NO

I have received and read the information sheet **(Inactivated Influenza VIS 2019-2020 dated 8/07/2015)** for the flu vaccination and have had the opportunity to ask questions. I understand the benefits and risks of the flu vaccination and request that it be given to me or the person named below for whom I am authorized to make this request.

FOR VACCINATOR USE

INFLUENZ VACCINE LOT #		TIME ADMINISTERED @ _____		R DELTOID IM 0.5mL GIVEN		L DELTOID IM 0.5mL GIVEN
MANUFACTURER	Sanofi					
EXPIRATION DATE						

VACCINATOR SIGNATURE _____ DATE _____

I the parent/guardian for student _____ (print student's name)

Information provided is correct to my knowledge and I give consent for the flu vaccine for the entire School year of 2019-2020

Parent Signature _____