Riverside University HEALTH SYSTEM Public Health

INACTIVATED INFLUENZA VACCINE

DATE: _____

SITE: _____

CONTACT:

INFLUENZA PROGRAM
PATIENT SCREENING CHECKLIST / CONSENT FORM / VACCINE ADMINISTRATION RECORD

PLEASE PRINT CLEARLY

Patient Name: _____ _____ _____
(Last) (First) (Middle)

Birthdate:_____ /_____ /_____ Age:_____ Gender (please circle): Male / Female

Address: _____ APT #: _____City: _____Zip Code_____

Contact Phone: _____

Mother's First Name: _____ Known Allergies: _____

Medical Alert:

Please answer **ALL** of the following questions by placing a check (√) under **YES** or **NO**. The questions are to be answered for the person receiving the vaccination. The Provider or Nurse giving the vaccination will review the information prior to vaccine administration.

	YES	NO
1. Is the person to be vaccinated sick today?	**	
**If YES, please discuss with Provider or Nurse?		
2. Does the person to be vaccinated have an allergy to ANY component of the vaccine?	**	
**If YES, please discuss with Provider or Nurse?		
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	**	
**If YES, please discuss with Provider or Nurse?		
4.Has the person to be vaccinated ever had Guillain-Barre' syndrome?	**	
**If YES, please discuss with Provider or Nurse.		
5. Is the person to be vaccinated pregnant?	**	
**If YES, please discuss with Provider or Nurse.		

Additional notes: _____

Request for Administration of Influenza Vaccine for the above named recipient: I have read or have had explained to me the information contained in the "Vaccine Information Statement" about the disease and the vaccine. I have had the chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that the vaccine indicated above be given to the person named above for whom I am authorized to make the request.

Patient or Parent/Guardian Signature **Date**

AREA FOR OFFICIAL USE ONLY

Dose # 1

DATE GIVEN_____ **VACCINE: Afluria / Fluarix / Fluzone**

LOT# _____ **Exp Date** _____

MFR: GSK / SANOFI / SEQIRUS **VIS Date: 8/6/2021**

DOSE: 0.5 ML **SITE: LT or RT DELTOID / LT or RT THIGH**

ROUTE: IM **CAIR Disclosure: YES NO Refused**

Patient education completed: Yes No

Nurse or MA Signature_____

Dose # 2 (if needed)

DATE GIVEN_____ **VACCINE: Afluria / Fluarix / Fluzone**

LOT# _____ **Exp Date**_____

MFR: GSK / SANOFI / SEQIRUS **VIS Date: 8/6/2021**

DOSE: 0.5 ML **SITE: LT or RT DELTOID / LT or RT THIGH**

ROUTE: IM **CAIR Disclosure: YES NO Refused**

Patient education completed: Yes No

Nurse or MA Signature_____

CAIR ID: **DATE ENTERED:**