

INFLUENZA VACCINE PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____

Primary Care Provider: _____

1. Vaccine Information Statement given: Yes No
 2. Allergy to any of the following:
 - Eggs/Poultry Yes No
 - Pork Yes No
 - Latex Yes No
 - Preservative thimersol Yes No
 3. Received flu vaccine in the past:
If yes, approximate date of last dose: _____
 4. Any previous reaction /problem with flu vaccines: Yes No
 5. Ever paralyzed by Guillian-Barre Syndrome: Yes No
 6. Currently experiencing any moderate to severe illness: Yes No
 7. Is your child less than 3 years of age: Yes No
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By signing I acknowledge the following:

I have read or have had explained to me the information in the "Vaccine Information Statement" regarding the risks and benefits associated with the influenza vaccination. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine recommended.

_____ Date: _____

Parent/Guardian Signature

For Office Use Only

Vaccine: Fluzone **Manufacturer:** Sanofi Pasteur **Lot#:** _____

Dose: 0.25ml or 0.5ml IM **Site:** Left or Right Thigh or Deltoid

_____ Date: _____

Administering Clinician's Signature