

**Flu Vaccination Form 2017-2018**

**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Org number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ATKS number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ***Please Check One*:**

 **□** SMMC Employee (under SMMC payroll) **□** Contracted Licensed Provider *(MD, PA, NP, DDS)*

 **□** Volunteer **□** Other Contracted Personnel or County Staff

 **□** Student/Intern (*e.g.* *PH,* *DPW, Security, PBX, Traveler, Registry, etc.)*

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| --- | --- | --- |
| **Please answer the following questions:** | **YES** | **NO** |
| ***I have read or have had explained to me the information on the vaccine information statement about influenza vaccine and that I understand the benefits and the risks of influenza vaccine. I also acknowledge that influenza vaccination is recommended by CDC for all healthcare workers to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community. I give consent to receive the flu vaccine.*** |  |  |
| **Do you have an allergy to eggs?** |  |  |
| **Have you ever had a serious reaction to previous dose of flu vaccine?** |  |  |
| **Have you ever had Guillain-Barre’ Syndrome (a type of temporary severe muscle weakness)** |  |  |
| **Do you have a fever or feel sick today?** |  |  |
| **Are you pregnant?** |  |  |
| **Are you 65 years old or above?** |  |  |

***Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**I received Influenza vaccination at another Institution \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (location)**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)**

|  |
| --- |
| ***For Employee Administering Vaccine Use Only:*** |
| **Site: 0.5 ml IM Deltoid L□ R□**  | **Name: Flulaval Quadrivalent** |
| **Nurse Administering vaccine** **(*Print Name*):** | **Lot Number: 4799F** |
| **Signature** | **Expiration date: 6/18/18** |

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