

## 2022 Influenza Vaccination Authorization

Name (print): \_\_\_\_\_ Maiden Name (if applicable): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Gender: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

Insurer's Date of Birth (if covered under parent or guardian insurance):  
\_\_\_\_\_

Answer the following questions:

1. Do you have a severe egg allergy or allergy to Thimerosal? Yes \_\_\_ No \_\_\_
2. Have you ever had a severe reaction to a flu shot? Yes \_\_\_ No \_\_\_
3. Are you now suffering from severe asthma, illness, cold or fever? Yes \_\_\_ No \_\_\_
4. Have you ever developed Guillain-Barre syndrome within six weeks of a previous dose of flu vaccine? Yes \_\_\_ No \_\_\_

I have read the information about influenza and the influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and request that the vaccine be given to me.

I understand I may experience mild soreness, redness or swelling at the injection site, fever, and/or muscle aches for 1 or 2 days, or I may experience no symptoms.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Self or Parent/Guardian (if under age 18 years)

-----  
Vaccinated by: \_\_\_\_\_ Lot # \_\_\_\_\_ Exp \_\_\_\_\_ Manufacturer \_\_\_\_\_  
(or place vaccine sticker)

Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

Site of Injection: RD \_\_\_ LD \_\_\_ RT \_\_\_ LT \_\_\_ 2<sup>nd</sup> dose needed: Yes \_\_\_ No \_\_\_