Patient Name: _____ **Date of Birth:** _____

Indications for Influenza Vaccine	Contraindication for Influenza Vaccine
☐ Standard dose vaccine - 6 months of age or older*	☐ Allergy to thiomersal (only applies to multi-dose vials)**
☐ High-Dose – vaccine - age 65 years and older	☐ Allergy to Neomycin or polymyxin (trace amount in Afluria)***
☐ High-Dose vaccine – 18-64 with solid organ transplant, taking immunosuppressants	☐ Allergy to Neomycin or kanamycin (trace amounts in Fluad)
	☐ Allergy to gentamicin (trace amounts in Flarix and Flumist)
Are you pregnant? Y / N (LAIV is contraindicated during pregnancy)	☐ Allergy to formaldehyde or octylphenol ethoxylate (ingredients in Fluzone & Fluzone HD)
	☐ Current fever / illness
	☐ Heart transplant within the last month
	☐ Bone marrow or stem cell transplant with the last 12 months
	☐ History of Guillain-Barre syndrome within 6 weeks of receiving influenza vaccine
	☐ History of serious reaction to influenza vaccine
	☐ Egg allergy
*age 6 months through 8 years should receive a second dose 1 month after the first dose if they have previously received less than 2 doses of influenza vaccine (total number of doses in the past).	**Thimerosal allergic patients may receive single dose Fluzone® ***Neomycin or polymyxin allergic may receive Fluzone®

Egg Allergy: Any influenza vaccine that is otherwise appropriate for the recipient's age and health status may be administered to someone with an egg allergy. All vaccines should be administered in settings in which personnel and equipment needed for rapid recognition and treatment of acute allergic reactions, including anaphylaxis, are available, regardless of allergy history.

Abbreviations:
IIV = Inactivated influenza vaccine
LAIV = Live attenuated influenza vaccine
RIV = Recombinant influenza Vaccine
HD (as a prefix) = High-dose vaccine

Date Vaccine Administered: _____

Verify the following information:

Vaccine Administered: _____
Vaccine Manufacturer: _____
Vaccine Lot Number(s): _____ **Exp. Date:** _____

IIV/RIV (including HD): Dose = 0.5 mL* Injection site: Deltoid / Thigh L _____ / R _____

***Afluria = 0.25 mL for age 6-35 months, 0.5 mL for age 3 years and above**

LAIV (only for age 2-49 years): Dose = 0.1 mL into each nostril

Administered by: _____ **Date/Time:** _____

☐ Do **NOT** administer any vaccines at this time.

CONSENT AND RELEASE STATEMENTS
I have received a copy of the Vaccination Information Sheet titled "What You Need to Know" for the vaccine(s) indicated above. I have read, or have had explained to me, the information contained in the Vaccine Information Statement including information on the risks and possible reactions associated with this 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 vaccine and requested that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

X_____ Date/Time: _____
Signature of person to receive vaccine/authorized representative

X_____ Date/Time: _____
Witness Signature

Patient Identification Label