



Influenza Vaccine 2022-2023

Health Screen and Permission Form

Full Name:	Date of Birth:	Age:	Gender: [] M [] F
Street Address:	Town/City:	Zip Code:	Race/Ethnicity:
Insurance Carrier (Auxiant, Cigna, BCBS, UHC..)	Member ID	Group #	Phone Number:

Please answer the following questions about the person named above who is receiving the vaccine.

- Does the individual receiving the vaccine **have a severe (life threatening) allergy to eggs?** [] Yes [] No
- Has the individual receiving the vaccine **ever had a severe reaction to an influenza immunization in the past?** [] Yes [] No
- Has the individual receiving the vaccine **ever had Guillain-Barre Syndrome?** [] Yes [] No
- Does the individual receiving the vaccine **have an allergy to Thimerosal or Latex?** [] Yes [] No

PERMISSION TO VACCINATE

- I was given a copy of the 2022 Influenza Vaccine Information Statement; I have read it or had them explained to me and I understand the benefits and risks of the Influenza vaccine.
- I give permission for a record of this vaccine to be maintained by the party administering it.
- I give permission that information be used to bill my insurance carrier for the cost of providing the vaccine.
- I give permission for the flu vaccine to be given to the person names above by signing below.**

X _____ Date: _____

Signature of parent or guardian if the person is a minor, or

Signature of adult to be vaccinated

Printed Name of Parent/Guardian or Adult to be Vaccinated: _____

FOR OFFICE USE ONLY:

Date Dose Administered	Vaccine Manufacturer	Lot Number	Dose administered	Signature of Vaccinator	Location of injection	Route	VIS date
			.5 mL			IM	8/06/21