All Heart
Homecare Agency

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Influenza Vaccination Form

Name: ______________________________

Date of Birth: ____________________ Sex: Female Male

Allergies: No Yes Specify: ____________________

Please answer the following questions:

1. Are you sick or do you have a fever today?	Yes	No	Don't Know
2. Have you ever had any reaction to influenza vaccine in the past, including Guillain-Barre syndrome?	Yes	No	Don't Know
3. Are you currently pregnant?	Yes	No	Don't Know

Consent

I have read the provided information about influenza vaccination or had such explained to me. I have had the opportunity to ask questions which have been answered to my satisfaction. I understand the benefits and risks of the vaccination and hereby request to be given the influenza vaccine.

Signature ____________________ Date __________

Influenza Vaccine Administration

Type of Vaccine ____________________ Dosage __________

Lot # ____________________ Expiration Date __________

Administered by ______________________________

Address ______________________________

Signature ____________________ Date __________

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