Seasonal Influenza Vaccination Downtime Form

I have read or have had explained to me the information about influenza and influenza vaccine. I have had an opportunity to discuss the benefits and risks of influenza vaccine with a healthcare provider of my choice before coming here today. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine.

Print full name*

Home address* **City*** **State*** **ZIP Code***

Email address **Phone number*** ***3/4 ID or Last 4 of SSN*** **Date of birth***

I have read/or been offered the CDC Flu Vaccination Statement (VIS) ☐ Yes

Consent to receive vaccine? ☐ Consent to receive vaccine ☐ Decline ☐ Already Received Vaccine

Is the person receiving the vaccine allergic to any component of the influenza vaccine? ☐ Yes ☐ No

Does the person receiving the vaccine have a latex allergy? ☐ Yes ☐ No

Has the person receiving the vaccine had a fever of at least 100.4 in the last 24 hours? ☐ Yes ☐ No

Has the person receiving the vaccine received a stem cell or bone marrow transplant within the last 4 months? ☐ Yes ☐ No

Does the person receiving the vaccine have a history of Guillain-Barré syndrome within 6 weeks of receiving an influenza vaccine? ☐ Yes ☐ No

Has the person receiving the vaccine ever experienced an anaphylactic reaction to the influenza vaccine? ☐ Yes ☐ No

Signature of person receiving vaccine **Date**

***Required**

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DO NOT WRITE IN THIS SPACE – NURSE USE ONLY (*Please complete legibly*)

3/4 ID of vaccinator*:_____ Lot number*:_____ Expiration Date*:_____

Vaccine manufacturer*:

☐ Sanofi Pasteur
☐ GlaxoSmithKline (GSK)
☐ Seqirus

Vaccine Product*:

☐ Fluzone Trivalent Pre-filled Syringe
☐ Fluzone High-Dose Trivalent (65+) Pre-filled Syringe
☐ Flucelvax Trivalent
☐ Fluarix Trivalent
☐ Flublok Trivalent Pre-filled Syringe
☐ Fluad Trivalent (65+0nly)

Location where vaccine was administered*:

☐ HCA Hospital
☐ HCA CareNow/MDNow
☐ HCA Physician Practice
☐ None of the above

Market Name*:_____ **Facility Name*:**_____

Vaccine location*:

☐ Left deltoid ☐ Right deltoid

Badge sticker provided?

☐ YES ☐ NO

_____ _____ _____

Signature of person completing form Date Time

***Required**