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2020-2021 WFBMC INFLUENZA VACCINATION AUTHORIZATION FORM

LEGAL NAME: _____

EMPLOYEE ID #:_____**DATE OF BIRTH:**_____/_____/_____**AGE:** _____

COMPANY NAME:_____**CONTACT # / EMAIL:** _____

INACTIVATED INFLUENZA VACCINE (INJECTABLE)

YES	NO	
❑	❑	1. Have you already had the influenza vaccine this season?
❑	❑	2. Are you allergic to any components of the influenza vaccine?
❑	❑	3. Have you received a stem cell or bone marrow transplant within the past 4 months?
❑	❑	4. Have you ever had Guillain-Barré Syndrome within 6 weeks of receiving a flu vaccination?
❑	❑	5. Have you ever had an anaphylactic reaction to the influenza vaccine? **
❑	❑	6. Have you had a temperature of 100.4° or greater in the past 24 hours?
❑	❑	7. Is this your first time getting a flu vaccine?

NOTE: ** An anaphylactic reaction is a rapidly developing and serious allergic reaction that affects a number of different areas of the body at one time.

❑ I have been given a copy of the CDC's Vaccination Information Statement (VIS) for Inactivated Influenza Vaccine

❑ I have read the VIS (Inactivated Influenza Vaccine 08/15/2019) and have had a chance to ask questions and fully understand the benefits and risks of vaccination with Inactivated Influenza Vaccine.

Signature:_____Date/Time: _____

For Office Use Only

Manufacturer/Vaccine Type	Dose Admin	Lot#/Exp. Date	Anatomical Site	
❑ Standard Quadrivalent	0.5 mL	_____	❑ LT Deltoid	❑ RT Deltoid
❑ High Dose Quadrivalent	0.5 mL	_____	❑ LT Deltoid	❑ RT Deltoid

Vaccinator Name (Print) Vaccinator Signature (Include Credentials) Date/Time