Dignity Health Medical Foundation

Influenza (Flu) Vaccine 2022/2023
Patient Vaccine Administration Form
Intramuscular Vaccine Injection

SECTION 1: Personal Information			
PATIENT NAME (Last)	(First)	(M.I.)	
MRN	**DOB (mm/dd/yyyy)**	**Age**	**VIS DATE**

SECTION 2: Screening for Vaccine Eligibility

Please answer the following questions for yourself/your child:

If your child is under the age of 9, have they received a flu vaccine in 2022/2023? Date:_____..... ☐ Yes ☐ No
Are you/your child currently experiencing symptoms of an acute illness? ..... ☐ Yes ☐ No
Have you/your child ever had a severe allergic reaction after a dose of flu vaccine (see VIS)? ..... ☐ Yes ☐ No
Are you/your child severely allergic to egg (yolks or whites) or have a known latex allergy? ..... ☐ Yes ☐ No
Have you/your child ever been diagnosed with Guillain-Barre Syndrome (GBS)? ..... ☐ Yes ☐ No
Have you had a history of severe allergic reaction to Neomycin (if so, do not administer Fluad® or Fluzone®) .. ☐ Yes ☐ No
Female Only: Is it possible you/your child is pregnant? (if so, do not administer FluMist® or MDV vaccine).... ☐ Yes ☐ No

If YES is answered for any question, CLINICIAN TO COMPLETE:

☐ I have reviewed and have made the clinical determination to PROCEED with vaccination – Signature_____

☐ I have reviewed and have made the clinical determination NOT TO PROCEED with vaccination.

SECTION 3: Consent for Vaccine

- I have read the above information and received a copy of the current Vaccine Information Sheet (VIS). I have had an opportunity to ask any questions, which have been answered to my satisfaction. I understand the benefits and risks of the influenza vaccine. I request that the vaccine be given to me or to the person named above for whom I am authorized to sign.

SIGNATURE REQUIRED (Guardian if under 18)		**DATE (mm/dd/yyyy)**
PARENT/GUARDIAN NAME if under 18 (Last)	(First)	**RELATIONSHIP**

SECTION 4: CLINIC USE ONLY – Vaccine Record

Vaccine Manufacturer:	☐ Flulaval-QIV 0.5 mL	☐ Fluad-QIV 0.5 mL	☐ Fluarix-QIV 0.5 mL
	☐ Flublok-QIV 0.5 mL	☐ Fluzone HD-QIV 0.5 mL	

NOTE: *All medication administration information must be entered in the EHR, including person who verified medication for Medical Assistants. All Clinical Staff acting on the DHMF SO-Pop: Vaccine – Influenza Written Order must document the Written Order requirements in the EHR.*

FORM TO BE SCANNED TO PATIENT'S EHR

(Revised 07.22.2022)