

Influenza Vaccination Recipient Interview
2017-2018

SUNY Potsdam ID# P00 _____

Information about person to receive vaccine (please print):

Name: _____ Date of Birth: _____ Age: _____
Last First M.I. mm/dd/yyyy

Local or Barrington Address: _____
Street or Box #
City State ZIP

Telephone #: _____ Family Physician: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- Allergy to eggs Yes No
Allergy to latex Yes No
Allergy to Thimerosal or Mercury Yes No
Previous reaction to flu vaccine Yes No
Blood disease Yes No
Guillain-Barre' Syndrome Yes No

PLEASE ANSWER THE FOLLOWING.

- Have you had any injections recently? Yes No
Have you been ill in the last 7 days? Yes No
Did this illness include a fever? Yes No
What is your weight? _____
Are you currently pregnant? (Females only) Yes No

ARE YOU TAKING ANY MEDICATION? YES NO

If yes, please list: _____

I certify I have received, read, and understand the CDC Influenza Vaccine Information Statement dated 08/07/15. I have answered the questions above to the best of my ability and consent to receive the flu vaccine today.

Signature of person to be vaccinated _____ Date _____

If the person to receive the vaccine is <18 years old, I certify I have received, read, and understand the CDC Influenza Vaccine Information Statement dated 08/07/15. I have answered the questions above to the best of my ability and I consent to allow the person named above to receive the flu vaccine today.

Signature of parent/guardian _____ Date _____

Please administer the 2017-2018 influenza vaccine: _____
Signature of Provider

(This record will be kept on file in Student Health Services.)