KATHERINE KRIEG, M.D., F.A.A.P. • SHARON NOVY, M.D., F.A.A.P.

1425 W. Elliot Rd., Suite 204 • Gilbert, Arizona 85233 • 480-792-1012 • Fax 480-792-1013

Adult Influenza Vaccine Administration Record

Patient Name:______________________________ Date of Birth:__________

Address:____

City:__________________ State:__________ Zip Code:__________________

Phone number:__________________ Primary care Dr.:____________________

Please circle Vaccine Desired Tdap Injectable Flu

1. Allergy to eggs/poultry? yes no
2. Allergy to the preservative Thimerosal? yes no
3. Allergy to latex? yes no
4. Any previous reaction or problem with flu vaccines? yes no
5. Currently experiencing any symptoms of illness? yes no
6. Been exposed to someone COVID positive in last 14 days? yes no
7. Pregnant? yes no

Acknowledgement and Waiver

I, the undersigned, wish to receive a vaccination against influenza. I am taking this vaccine voluntarily and consent to the vaccination being given to me. I have been offered or had explained to me the information in the "Vaccine Information Statement" regarding the risks and benefits associated with the influenza vaccination. I have had a chance to ask questions that were answered to my satisfaction. I give consent for this vaccine to be documented in the Arizona State immunization information system per legal requirements.

______________________________________ Date: ____________

Patient Signature

For office use only

Vaccine: Fluarix Flulavol Manufacturer:

Lot#:______________ Site: Left Right Deltoid

______________________________________ Date:____________

Administering Clinician's Signature