All Heart
Homecare Agency

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Tel: 718.627.0300 Fax: 718.627.0330

Influenza Vaccination Form

Name: _____

Date of Birth: _____ Sex: ☐ Female ☐ Male

Allergies: ☐ No ☐ Yes Specify: _____

Please answer the following questions:

1. Are you sick or do you have a fever today?	☐ Yes	☐ No	☐ Don't Know
2. Have you ever had any reaction to influenza vaccine in the past, including Guillain-Barre syndrome?	☐ Yes	☐ No	☐ Don't Know
3. Are you currently pregnant?	☐ Yes	☐ No	☐ Don't Know

Consent

I have read the provided information about influenza vaccination or had such explained to me. I have had the opportunity to ask questions which have been answered to my satisfaction. I understand the benefits and risks of the vaccination and hereby request to be given the influenza vaccine.

Signature _____ Date _____

Influenza Vaccine Administration

Type of Vaccine _____ Dosage _____

Lot # _____ Expiration Date _____

Administered by _____

Address _____

Signature _____ Date _____