Rocky Mountain Urgent Care & Family Medicine

Influenza Vaccine Administration Record

Office: Aurora Boulder Englewood Lakewood Lowry Longmont Reunion Smoky Hill Westminster Other

Patient Name: _____

Gender: Male Female **Birth Date**: _____ **Age**: _____

Name of Parent/Guardian: _____ **Phone**: _____

Street Address: _____

Apt#_____ **City:** _____ **Zip Code**: _____

1. Is the patient sick today? YES NO

   Symptoms: _____

2. Has the patient had a reaction to egg proteins (eggs or egg products), chicken protein, or a previous dose of any vaccine? YES NO

3. Has the patient ever had Guillian-Barre Syndrome? YES NO

I have read the information contained in the Vaccine Information Sheet (dated ___-____-____) about the vaccine. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and the risks of the vaccine and ask that the vaccine be given to me or to the individual named above for whom I am authorized to make this request.

I have been given information about the notice of Privacy Practices and was offered a copy of it if so requested.

Signature: _____ Printed Name: _____

Back Office use only

Date Vaccine Administered: ____-____-_____ Vaccine Manufacturer:_____

Vaccine Lot Number: _____ Expiration Date: ____-____-_____ Site of Injection_____

Signature of Vaccine Administrator: _____Date: _____

Payment: (Circle One) Card# _____ Cash Check#_____

Employee Printed Name_____