

## Traill District Health Unit Administration Record

I have read or have had explained to me the information about influenza and influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

Name (Last, First, MI)							
Date of Birth:		Age	Phone #				
Mailing Address:							
City, State, Zip							
<b>Does your child have any of the following:</b>				<b>Please list insurance # that covers your child's vaccines</b>			
<b>Check yes or no</b>	yes	no	<b>Insurance Name</b>		<b>Number</b>		
Allergies to medicines			BCBS				
Egg Allergy			MNBCBS				
Latex Allergy			Medicare				
Illness Today			Medicaid				
Fever Today			Sanford Health				
History of Guillain-Barre			Other				
Previous reaction to flu shot							
<b>Signature:</b>				<b>Date:</b>			
<b>For Clinic Use Only</b>							
Vaccine name	Mfg.	Lot #	Exp. date		Admin site	VIS date	Offered
Fluzone QUAD	SP	UT7005KA	6-30-2021			8-15-2019	
<b>Vaccine administrator:</b>				<b>Date</b>			