Employer: **\_\_\_\_\_MLC\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_ **(Check here if you are a spouse )**

If employee spouse, please list employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injection: **\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Please fill out below completely***

Full legal name (print):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Your address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_X\_\_\_**Send charge to the medical insurance - **Provide a photo copy of health insurance**

**\_\_\_\_\_** My employer is going to pay for my vaccine

Fluarix Quadrivalent – GSK

Lot# 9775G – Exp. 5/9/17

**R** or **L** Deltoid IM 0.5 ml

Dr. TJ Knowles/ M Dake RN

**\_\_\_\_\_**The employee received the CDC *Vaccination Information*

*Statement* posted August 2015

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Are you allergic to the eggs or egg products?  |  | YES | NO |
| 2. Are you allergic to Thimerosol (a preservative) other than contact lens solution? |  | YES | NO |
| 3. Have you ever had Guillian-Barre Syndrome?  |  | YES | NO |
| 4. Have you ever had an anaphylactic reaction to the Influenza vaccine? |  | YES | NO |
| 5. Are you allergic to latex or rubber products?  |  | YES | NO |
| 6. Have you received the vaccine against the flu before?  |  | YES | NO |
| 7. Are you moderately or severely ill today?  |  | YES | NO |
| 8. For female employees: Are you pregnant?  |  | YES | NO |

**I have answered the above questions about the influenza vaccine. I also understand the risks and benefits of it. I request that the vaccine be given to me.**

Signature of Person to Receive Vaccine: Date / Time

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Original**FAVOR DE COMPLETAR ESTE QUESTIONARIO ANTES DE RECIBIR SU VACUNA