Student Flu Vaccine Administration Record 2023-2024

Student ID #: _____

Fill in all information through the red X. *Vaccine Information Statements can be viewed at www.cdc.gov/immunize.*

Last name:	First name:	M.I.:	Age:	Date of Birth:	Gender: M F (circle)

Current Address				Race: (please check all that apply):	Born in what state:
	Street or PO Box:			☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black or African American ☐ Hawaiian Native/Pacific Islander ☐ White	If not born in US, what country:
	City:				
	State:	Zip Code:	County:		Ethnicity: Non-Hispanic Hispanic

Home or Cell Phone#	Mother's maiden name (if patient is 18 years or younger):

Health History

Please answer all the questions:	✔ Check Yes or No	
Do you feel sick today?	☐ Yes	☐ No
Have you had any of the following symptoms in the past 14 days: Cough, muscle pain fever (temp > 100.4F), unexpected shortness of breath, chills, or sore throat, loss of taste/odor?	☐ Yes	☐ No
Have you been in contact with anyone with confirmed or suspected Coronavirus (COVID-19) infection within the past 14 days?	☐ Yes	☐ No
Ever has a serious reaction after previous vaccines?	☐ Yes	☐ No
Allergies to medicine, latex or food including eggs or gelatin? Please list: _____	☐ Yes	☐ No
Ever had a seizure; nervous system, muscle or nerve disorder; or Guillian Barre (paralyzing polio)?	☐ Yes	☐ No
Have a weak immune system from HIV, or other diseases?	☐ Yes	☐ No
Received a blood transfusion, blood products or Immune Globulin in the past 12 months?	☐ Yes	☐ No
On medication such as prednisone, cortisone, steroids or medication used to treat cancer or arthritis?	☐ Yes	☐ No
Having x-ray therapy for cancer?	☐ Yes	☐ No
Had MMR vaccine (measles, mumps, and rubella), Chickenpox vaccine or live flu vaccine in last 4 weeks?	☐ Yes	☐ No
Pregnant?	☐ Yes	☐ No
Long term health problem such as heart, lung, asthma, diabetes, kidney or blood disorder?	☐ Yes	☐ No

Authorization and Assignment of Benefits

A copy of the Vaccine Information Statement has been provided, and I have read, or had explained, the information about the disease(s) and the vaccine(s) listed. I had an opportunity to ask questions and believe that I understand the benefits and risks of the vaccine(s). I consent to the administration of the vaccines listed to be given to the person named above, and I am authorized to give this consent. Minot State University Student Health Center (Minot State SHC) Notice of Privacy Practices is available online or by request. I agree to pay, and I am financially responsible for Minot State SHC established charges that are not covered by a third-party payer. Information collected on this form will be used to document receipt of vaccine(s) and may be shared with the ND Immunization Information System and other entities in accordance with ND Century Code 23-01-05.3.

X _____ **Date:** _____

Signature of client or person authorized to sign on the client's behalf.

Minot State University Student Health Center OFFICE USE ONLY							
✔	Vaccine(s) to be given	Route*	VIS Date	Manufacturer	Lot # AF749	Admin. Site	Person Admin.
	Influenza (private)	IM	8/6/2021	GSK	Fluarix QIV (GSK)Exp. 6/30/2024	RA LA	

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Nursing Assessment/Teaching/Vaccine Administration **Date**