North Central Health Care
Person centered. Outcome focused.

Influenza Vaccination Employee Statement

I am aware of the influenza policy and have had a chance to have my questions answered about influenza vaccination. I understand the benefits and risks of the vaccine, and by signing below I **agree** to have the influenza vaccine for the 2024 influenza season.

Print Name	Date of Birth	Today's Date

Signature	Program

Parent/Guardian signature (if under age 18)	Today's Date

Influenza Vaccination Administration

Flu vaccination screening questions:	1) Are you sick today?	☐ Yes	☐ No
	2) Do you have any life-threatening allergies to a component of the influenza vaccine? Please List:	☐ Yes	☐ No
	3) Have you had a life-threatening reaction to an influenza vaccine in the past?	☐ Yes	☐ No
	4) Have you ever had Guillain-Barre syndrome?	☐ Yes	☐ No
	5) Is this the first time you have received an influenza vaccine?	☐ Yes	☐ No

Already vaccinated: ☐ I have already been vaccinated against influenza this season**. Please provide proof**.	Date of vaccination:_____ Place vaccine was received: _____ ***Please provide a copy of Influenza vaccination with this form**

Administrative Use Only		
Name of Vaccination: Influenza Vaccine		
Date administered/VIS given:____/____/_____		Date of VIS: 8/06/2021
Vaccine: Fluzone 2024/2025 Formula		
Lot #: UT8423JA U8518AA U8523AA	Mfg: Sanofi	**Site:** ☐ **Left Deltoid** ☐ **Right Deltoid**
Dose: 0.5 ml.	Exp. Date: 6/30/2025	**Name and title of vaccine administrator:**

Documented in WIR Date and Initials: _____/_____