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		

Does your child have any of the following:		
Check yes or no	yes	no
Allergies to medicines		
Egg Allergy		
Latex Allergy		
Illness Today		
Fever Today		
History of Guillain-Barre		
Previous reaction to flu shot		

Please list insurance # that covers your child's vaccines

Insurance Name	**Number**
BCBS	
MNBCBS	
Medicare	
Medicaid	
Sanford Health	
Other	

Signature: **Date:**

For Clinic Use Only

Vaccine name	Mfg.	Lot #	Exp. date		Admin site	VIS date	Offered
Fluzone QUAD	SP	UT7005KA	6-30-2021			8-15-2019	

Vaccine administrator: **Date**