Flu Shot Consent Form

Please circle your response:

1. Have you had a flu shot before? Yes No
   If yes, what was the date? _____
2. Are you allergic to eggs? Yes No
3. Are you currently taking an antibiotic for infection? Yes No
4. Do you feel ill today or do you have a fever? Yes No
5. If you are female, are you pregnant? Yes No

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PRINT NAME: _____ DATE OF BIRTH _____

Signature of person receiving vaccine:

_____ Date _____/_____/2021

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Lot # FT779

Expiration Date: 6/2022 Administration Date: _____

Site of Injection: R L Deltoid

Signature of Vaccine Administrator: _____