Inactivated Influenza Vaccine **Outpatient Flu Vaccination Record 2015-2016**

Patient Name:_____ Date:_____

MR#:_____ EOH Use Only - Employee #_____

Please answer the following questions:

1. Any history of allergies to eggs or latex? ☐ Yes ☐ No
2. Previous sensitivity to thimerosal – a preservative? ☐ Yes** ☐ No
3. Cold, fever greater than 100 degrees Fahrenheit, acute respiratory disease, or any other sign of infection? ☐ Yes ☐ No
4. Previous severe reaction to a flu vaccine? ☐ Yes ☐ No
5. History of seizure brought on by a fever? ☐ Yes ☐ No
6. History of Guillain-Barre Syndrome? ☐ Yes ☐ No

If yes is checked in any box, the patient must be referred to a provider for further evaluation.
***If yes, prefilled syringes or single use vials are the recommended flu vaccines for persons with thimerosal sensitivity. Review dosing schedule and package insert to confirm vaccine components prior to vaccine selection.*

I have read the vaccine information sheet (VIS) regarding the inactivated flu vaccine. I have had an opportunity to ask questions regarding the flu; flu vaccines; risks, as well as the usual and infrequent side effects. I have truthfully answered the above questions and the special precautions do NOT apply. I request that the inactivated flu vaccine be given. I understand that it would be best if I remain in the clinic for 15 minutes following administration of the vaccine in the event that I experience any adverse reactions. If I choose not to stay the recommended time, I will immediately contact my provider if I have symptoms that may be related to receiving the flu vaccine or I will go to the nearest emergency room.

_____ _____ _____
Patient's Name (please print) Date of birth Age

_____ _____ _____
Signature of person receiving vaccine (or parent/guardian) Date / Time Relationship to patient

Administer flu vaccine based on guidelines on back of this document.

Date/Time	Dosage	Route: circle location	Manufacturer	Lot # / Expire Date	VIS Date	Clinical Staff Signature
1.	_____ml	Intradermal _____Deltoid IM_____ Deltoid / Thigh				
2.	_____ml	IM_____ Deltoid / Thigh				

Note: For adults and older children, the recommended site is the deltoid muscle – Needle size 22-25g 1 to 1.5 inch in length. For infants and young children lacking adequate deltoid mass, the preferred site is the anterolateral aspect of the thigh (vastus lateralis). Needle size 22-25g 1 to 1 1/4 inch in length.

If limited English proficient or hearing impaired, offer interpreter at no additional cost.

☐ Interpreter Accepted _____ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

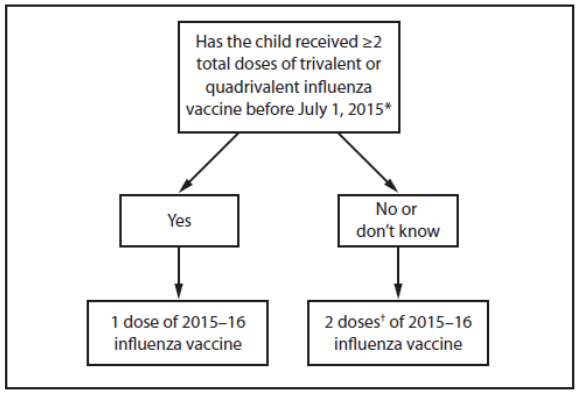
Trade Name	Age Group	Dosage	Number of Doses	Route
Afluria Trivalent (bioCSL) (no preservatives or latex)	≥ 9 years	0.5 mL prefilled syringe	1	Intramuscular
Afluria Trivalent (bioCSL) (no latex)	≥ 9 years	0.5 mL from a 5 mL multi-dose vial	1	Intramuscular
Fluarix Quadrivalent (GSK) (no latex or preservatives)	≥ 3 years*	0.5 mL prefilled syringe	**Age up to 8 years:** 1 or 2 (1 month apart) doses depending on vaccination history per ACIP recommendations* **Age ≥ 9 years:** 1 dose ***Refer to Figure 1 below**	Intramuscular
Flucelvax Trivalent (Novartis) (eggless) (no preservative or antibiotics)	≥ 18 years	0.5 ml prefilled syringe	1	Intramuscular
FluLaval Quadrivalent (GSK) (no latex)	≥ 3 years*	0.5 mL from a 5 mL multidose vial	**Age up to 8 years:** 1 or 2 (1 month apart) doses depending on vaccination history per ACIP recommendations* **Age ≥ 9 years:** 1 dose ***Refer to Figure 1 below**	Intramuscular
Fluvirin Trivalent (Novartis) (no latex)	≥ 4 years*	0.5 mL from a 5 mL multidose vial		
Fluvirin Trivalent (Novartis)	≥ 4 years*	0.5 mL prefilled syringe		
Fluzone (Trivalent) (Sanofi Past) (no latex)	6 months – 35 months*	0.25 mL from a 5 mL multidose vial	1 or 2 (1 month apart) doses depending on vaccination history per ACIP recommendations* ***Refer to Figure 1 below**	Intramuscular
Fluzone Quadrivalent (Sanofi Past) (no latex)	6 months – 35 months*	0.25 mL from a 5 mL multidose vial	1 or 2 (1 month apart) doses depending on vaccination history per ACIP recommendations* ***Refer to Figure 1 below**	Intramuscular
Fluzone Quadrivalent (Sanofi Past) (no preservatives or latex)	6 months – 35 months*	0.25 prefilled syringe		
Fluzone (Trivalent) (Sanofi Past) (no latex)	≥ 36 months*	0.5 mL from a 5 mL multidose vial	**Age up to 8 years:** 1 or 2 (1 month apart) doses depending on vaccination history per ACIP recommendations* **Age ≥ 9 years:** 1 dose ***Refer to Figure 1 below**	Intramuscular
Fluzone Quadrivalent (Sanofi Past) (no latex)	≥ 36 months*	0.5 mL from a 5 mL multidose vial		
Fluzone Quadrivalent (Sanofi Past) (no preservatives or latex)	≥ 36 months*	0.5 prefilled syringe		
Fluzone Quadrivalent (Sanofi Past) (no preservatives or latex)	≥ 36 months*	0.5 mL vial (single dose vial)		
Fluzone High Dose Trivalent (Sanofi Past) (no preservatives or latex)	≥ 65 years	0.5 mL prefilled syringe	1	Intramuscular
Fluzone Intradermal Quadrivalent (Sanofi Past) (No preservatives or latex)	18 – 64 years	0.1 mL prefilled microinjection system syringe	1	**Intradermal**

***For patients ≥ 9 years old – single 0.5 mL dose**

***For children aged 6 months to < 9 years**

Single dose appropriate for age if history of prior seasonal vaccination. See dosing chart and Figure 1 dosing algorithm.
Two doses appropriate for age about 4 weeks apart if first ever seasonal vaccine. See dosing chart and Figure 1 dosing algorithm.

FIGURE 1. Influenza vaccine dosing algorithm for children aged 6 months through 8 years — Advisory Committee on Immunization Practices, United States, 2015–16 influenza season



* The two doses need not have been received during the same season or consecutive seasons.
† Doses should be administered ≥4 weeks apart.