OnSiteHealth
HEALTH CARE SOLUTIONS AT WORK...SINCE 2005

INFLUENZA VACCINE

Last Name	First Name	Date	Company/Organization

Known Allergies? _____

Do you currently have a fever or illness?	Yes_____	No_____
Are you allergic to eggs or chicken?	Yes_____	No_____
Have you had the flu vaccine in the past?	Yes_____	No_____
If yes, did you have a reaction to the vaccine?	Yes_____	No_____
(Women only) Are you pregnant or breast feeding?	Yes_____	No_____
(Women only) If yes, has your doctor approved your receipt of a flu shot?	Yes_____	No_____

I have read or had explained to me the information on the information sheet. I believe I understand the benefits and risks of the vaccine and am waiving my employer and On-Site Health Solutions of any liability with regard to the vaccine and the vaccination process. I ask that this vaccine be administered to me or to the person for whom I am authorized to make this request.

Signature: _____ Date: _____

Site: Right Deltoid_____ Left Deltoid_____ Other _____ Given by: _____

Influenza Virus Vaccine: **AFLURIA** **Lot #** **P100** **exp.** **05/27/2021**
Quadrivalent

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