**Flu Vaccine (IM) Questionnaire**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you have a chart at I.H.S? Yes No

* Have you had a flu shot since September 1st, 2019? Yes No
* Have you ever had a severe reaction to a flu shot in the past? Yes No
* Are you sick or do you have a fever today? Yes No
* Are you allergic to eggs? Yes No
* Do you have seizures or other nervous system problems? Yes No

Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lot#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_