



2017 Seasonal Influenza Employee Consent for Immunization

Last Name: _____ First Name: _____
Birth date: (yyyy/mm/dd) _____ <18 Home Facility of work: _____
Employee #: _____ other

Note:
If your date of birth is between 1952/Jan/01 - 1953/Mar/31, you may qualify for a pneumococcal vaccine. Please ask the nurse.

The names of immunized employees will be provided in confidence to the employee's department head in order to determine fitness for work and direct workplace and outbreak processes.

For Completion by Nurse:

Clinic Location: _____ Date: (yyyy/mm/dd) _____

Influenza Vaccine

FluLaval Tetra Lot # **2ZK7F** 0.5 ml IM
 Fluzone Lot # _____ 0.5 ml IM

Nurse's Initials: _____

Entered on Spreadsheet

Site:
<input type="checkbox"/> RA
<input type="checkbox"/> LA

Follow Up Required/Nurse Comments: Client phone # _____: