

Patient Name: _____

Date: _____

MR#: _____

EOH Use Only - Team Member # _____

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 Team Member Signature
1.	_____ ml	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)



Patient Name: _____

DOB: _____

Or label

Name / MR # / Label

Trade Name	Age Group	Dosage	Number of Doses	Route
FluLaval quadrivalent (GSK) (no preservative) (no latex)	≥ 6 months	0.5 mL prefilled syringe	Age up to 8 years: 1 or 2 (at least 4 weeks apart) doses depending on vaccination history per ACIP recommendations* Age ≥ 9 years: 1 dose *Refer to Figure 1 below	Intramuscular
Flucelvax quadrivalent (Seqirus) (eggless) (no preservative or antibiotics) (No latex)	≥ 4 years	0.5 mL prefilled syringe	Age up to 8 years: 1 or 2 (at least 4 weeks apart) doses depending on vaccination history per ACIP recommendations* Age ≥ 9 years: 1 dose *Refer to Figure 1 below	Intramuscular
FluAD adjuvant (Seqirus) (preservative free) (contains eggs and syringe tip contains latex)	≥ 65 years	0.5 mL prefilled syringe	1	Intramuscular
INFLUENZA VACCINE SUPPLIED THROUGH THE VACCINE FOR CHILDREN PROGRAM ONLY				
Trade Name	Age Group	Dosage	Number of Doses	Route
Fluarix quadrivalent (GSK) (no preservatives)	≥ 36 months* - 18 years (VFC Program Only)	0.5 mL prefilled syringe	Age up to 8 years: 1 or 2 (at least 4 weeks apart) doses depending on vaccination history per ACIP recommendations* Age ≥ 9 years: 1 dose *Refer to Figure 1 below	Intramuscular
FluLaval quadrivalent (GSK) (no preservative) (no latex)	≥ 6 months* – 18 years (VFC Program Only)	0.5 mL prefilled syringe	Age up to 8 years: 1 or 2 (at least 4 weeks apart) doses depending on vaccination history per ACIP recommendations* Age ≥ 9 years: 1 dose *Refer to Figure 1 below	Intramuscular
Flucelvax quadrivalent (Seqirus) (eggless) (no preservative or antibiotics) (No latex)	≥ 4 years – 18 years* (VFC Program Only)	0.5 mL prefilled syringe	Age up to 8 years: 1 or 2 (at least 4 weeks apart) doses depending on vaccination history per ACIP recommendations* Age ≥ 9 years: 1 dose *Refer to Figure 1 below	Intramuscular
Fluzone quadrivalent (Sanofi) (no latex or antibiotics) (contains preservative)	6 months – 35 months* (VFC Program Only)	0.25 mL from a 5 mL multidose vial	1 or 2 (at least 4 weeks apart) doses depending on vaccination history per ACIP recommendations* *Refer to Figure 1 below	Intramuscular
Fluzone quadrivalent (Sanofi) (no latex, preservatives or antibiotics)	6 months – 35 months* (VFC Program Only)	0.25 mL prefilled syringe		
Fluzone Quadrivalent (Sanofi) (no latex or antibiotics)	≥ 36 months - 18 years* (VFC Program Only)	0.5 mL from a 5 mL multidose vial	Age up to 8 years: 1 or 2 (at least 4 weeks apart) doses depending on vaccination history per ACIP recommendations* Age ≥ 9 years: 1 dose *Refer to Figure 1 below	Intramuscular
Fluzone Quadrivalent (Sanofi) (no latex, preservatives or antibiotics)	≥ 36 months – 18 years* (VFC Program Only)	0.5 mL prefilled syringe		
Fluzone quadrivalent (Sanofi) no latex, preservatives or antibiotics)	≥ 36 months - 18 years* (VFC Program Only)	0.5 mL single dose vial	Age up to 8 years: 1 or 2 (at least 4 weeks apart) doses depending on vaccination history per ACIP recommendations* Age ≥ 9 years: 1 dose *Refer to Figure 1 below	Intramuscular

*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. Influenza vaccine dosing algorithm for children aged 6 months through 8 years – Advisory Committee on Immunization Practices, United States, 2017–18 influenza season

