



Ball Memorial Physicians

INFLUENZA VACCINE 2011/2012

I have been provided a copy or have had explained to me, the Centers for Disease Control and Prevention 2011-2012 Influenza Vaccine Information Sheet. I have had a chance to ask questions and they were answered to my satisfaction. I believe that I understand the benefits and risks of the influenza vaccine and ask that the influenza vaccine to be given to me or to the person named below for whom I am authorized to make this request:

PLEASE CHECK:

IU Health Ball Memorial Physicians Patient: _____ PATIENT'S PHYSICIAN: _____

ARE YOU ALLERGIC TO EGGS, FORMALDEHYDE, GELATIN OR HAVE A HISTORY OF GUILLAIN-BARRE' SYNDROME YES _____ NO _____

ARE YOU ALLERGIC TO LATEX YES _____ NO _____

Last name _____ First _____ Middle Initial _____

Date of Birth (month/day/year) _____/_____/_____

Address: _____ City _____

State _____ Zip Code _____

SIGNATURE OF VACCINE RECIPIENT: _____

IF VACCINE RECIPIENT IS UNDER 18 YRS OF AGE, A SIGNATURE OF A GUARDIAN IS REQUIRED:

Relationship & Signature

FOR CLINIC USE ONLY

Clinic Name: BALL STATE EMPLOYEE QUICK CLINIC

Date Vaccinated: _____ Manufacturer and Lot # NOVARTIS _____ Exp. _____

Site of Injection: Circle: Lt. Rt. Deltoid

Signature & Title of Administrator of Injection: _____