Van's Institutional Pharmacy
Healthcare for life.

Flu Vaccine Administration Record 2025-2026

Please complete the following:

Patient Name		
Date of Birth		Medication Allergies
Social Security #		Medicare Part B # (if different from SSN)
Address or Facility Name		
Phone Number		
Primary Doctor		

Have you been vaccinated with a seasonal flu vaccine in the past? YES ☐ NO ☐

Please answer the following questions with a check under the appropriate response:

	Yes	No	Unsure
1. Do you feel sick today?			
2. Do you have allergies to any foods or vaccines? Allergy to eggs? If yes, please include additional information below.			
3. Have you received any vaccination in the past 4 weeks? If yes, please list vaccine.			
4. Have you ever had a serious reaction to an influenza vaccine or other vaccine in the past?			
5. Have you ever had a seizure disorder for which you take seizure medication(s), a brain disorder, Guillan-Barre Syndrome (a condition that causes paralysis) or other nervous system problem?			
6. For women: Are you pregnant or are you considering becoming pregnant in the next month?			

By signing below, I confirm that I have answered the above questions to the best of my knowledge. I also confirm that I am the person listed above and am at least 18 years of age. I understand that as with any medication, serious problems, even death can occur. The risks from the vaccine are much smaller than the risks from the disease. I further certify that I have been given the Vaccine Information Statement for influenza and have had all the questions regarding the vaccine answered appropriately.

Patient/Conservator Signature:_____ Date: _____

For ADMINISTRATION Use Only: 2025/26 FLU VACCINE - INTRAMUSCULAR ONE TIME DOSE, PRESERVATIVE FREE

☐ FLULAVAL TRIVALENT GSK 0.5ML ☐ AFLURIA TRIVALENT SEQ 0.5ML

☐ FLUZONE HD TRIVALENT ☐ OTHER:_____

INJECTION SITE – ☐RIGHT DELTOID ☐LEFT DELTOID

Name:_____ Date: _____