Student Flu Vaccine Administration Record 2024-2025

Student ID #: _____

Fill in all information through the red X. *Vaccine Information Statements can be viewed at www.cdc.gov/immunize.*

Last name:	First name:	M.I.:	Age:	Date of Birth:	Gender: M / F (circle)

Current Address					
Street or PO Box:			**Race: (please check all that apply):** ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black or African American ☐ Hawaiian Native/Pacific Islander ☐ White	**Born in what state:** If not born in US, what country:	
City:					
State:	**Zip Code:**	**County:**		**Ethnicity:** Non-Hispanic Hispanic	

Home or Cell Phone#	Mother's maiden name (if patient is 18 years or younger):

Health History

Please answer all the questions:	✔ Check Yes or No	
1. Is the person to be vaccinated sick today?	☐ Yes	☐ No
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	☐ Yes	☐ No
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐ Yes	☐ No
4. Has the person to be vaccinated ever had Guillain Barré Syndrome?	☐ Yes	☐ No
5. Had MMR vaccine (measles, mumps, and rubella), Chickenpox vaccine or live flu vaccine in last 4 weeks?	☐ Yes	☐ No

Authorization and Assignment of Benefits

A copy of the Vaccine Information Statement has been provided, and I have read, or had explained, the information about the disease(s) and the vaccine(s) listed. I had an opportunity to ask questions and believe that I understand the benefits and risks of the vaccine(s). I consent to the administration of the vaccines listed to be given to the person named above, and I am authorized to give this consent. Minot State University Student Health Center (Minot State SHC) Notice of Privacy Practices is available online or by request. I agree to pay, and I am financially responsible for Minot State SHC established charges that are not covered by a third-party payer. Information collected on this form will be used to document receipt of vaccine(s) and may be shared with the ND Immunization Information System and other entities in accordance with ND Century Code 23-01-05.3.

X _____ **Date:** _____

Signature of client or person authorized to sign on the client's behalf.

Minot State University Student Health Center OFFICE USE ONLY							
✔	Vaccine(s) to be given	Route*	VIS Date	Manufacturer	Lot # 9CH4P	Admin. Site	Person Admin.
	Influenza (private)	IM	8/6/2021	GSK	Fluarix QIV (GSK)Exp. 6/30/2025	RA/LA	

_____ _____

Nursing Assessment/Teaching/Vaccine Administration **Date**

9/26/2024