Student Flu Vaccine Administration Record 2026-2027

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

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:				**Ethnicity:** ☐ Non-Hispanic ☐ Hispanic
	State:	**Zip Code:**	**County:**		

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

Health History		
Please answer all 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 influenza. 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. I assign and authorize any third party payer/insurer to make direct payment to Minot State University Student Health Center. I authorize the release of information necessary to process this claim. 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 _____ _____

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

Minot State University Student Health Center OFFICE USE ONLY							
✔	Vaccine(s) to be given	Route*	VIS Date	Manufacturer	Lot #E5SL2	Admin. Site	Person Admin.
	Influenza (private)	IM	1/31/2025	GSK	Fluarix QIV (GSK) Exp. 6/30/2027	RA/LA	

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