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Name of Service

VACCINE ADMINISTRATION RECORD

Information collected on this form will be used to document authorization of receipt of influenza vaccine. Information may be shared through the North Dakota Immunization Information System (NDIIS) and with other entities in accordance with North Dakota Century Code 23-01-05.3

Print Patient's Name (Last, First, Middle Initial):	Date of Birth:	Age:	☐ Male ☐ Female
Address (Street or PO Box):	City:	State:	Zip Code
Home Phone #	Cell Phone #:	Work Phone #:	

Please Check Appropriate Box - X	**YES**	**NO**
Do you have a fever OR are you ill today?		
Have you had a serious reaction to a previous dose of influenza vaccine?		
Have you had a serious allergic reaction to eggs requiring emergency care?		
Do you have a history of Guillain-Barre Syndrome?		
Is this the first time you have received an influenza vaccination?		
If you would like the FluMist Vaccine (if available), please complete the following questions	**YES**	**NO**
Do you have a long term problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (diabetes), anemia or other blood disorders?		
Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as steroid, or cancer treatment with X-rays or drugs?		
Are you taking aspirin or receiving aspirin containing therapy?		
Are you pregnant or plan on becoming pregnant within the next month?		
Do you live with or expect ot have close contact with a person whose immune system is severely compromised and whom must be in a protective enviroment (such as a hospital room with reverse air flow)		
Have you received any other vaccinations in the past four (4) weeks?		

A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement(s) has been provided. I have read, or have had explained, the information about the disease and the vaccine listed below. There was an opportunity to ask questions and all questions were answered satisfactorily. I believe that I understand the benefits and risks of the vaccine cited and ask that the vaccine listed be given to me.

_____ _____

Signature of Patient Date

For Service Use ONLY:

Date of Vaccination_____

VACCINE ADMINISTRATION

X	**Vaccine to be Given**	**VIS Date**	**Manufacturer**	**Dosage**	**Admin Site**	**Paramedic Signature**
	Influenza			0.5 ml	**LA RA LT RT**	
	FluMist			0.1 ml per nostril	**Nasal**	