

***Influenza Vaccination Form 2016-2017***

***Please Print Clearly*:**

**Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Title**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Department/Unit**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employee/ATKS number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Department Org** #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I have read or have had explained to me the information on the vaccine information statement about influenza vaccine and that I understand the benefits and the risks of the influenza vaccine. I also acknowledge that influenza vaccination is recommended by CDC for all healthcare workers to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.***

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Please Check One*:**

**□** SMMC Employee (under SMMC payroll) **□** Contracted Licensed Provider *(MD, PA, NP, DDS)*

**□** Volunteer **□** Other Contracted Personnel or County Staff

**□** Student/Intern (*e.g.* *PH,* *DPW, Security, PBX, Traveler, Registry etc)*

***Influenza vaccination received at another Institution \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Location)***

***on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Date)***

|  |  |
| --- | --- |
| ***For Employee Administering Vaccine Use Only:*** | |
| **Site: 0.5 ml IM Deltoid L□ R□** | **Name: FLULAVAL** |
| **Nurse Administering vaccine**  **(*Print Name*):** | **Lot Number: 5S349** |
| **Signature** | **Expiration date: May 31, 2017** |

***Flu form 2016-2017***