Vaccine Registration

First Name: ______________________________ **Middle Initial:** ___

Last Name: _______________________________ **Date of Birth:** ___/____/______

Cell Phone Number: _______________________

Address: ____

Address City/State Zip

Email Address: ____

Race (Circle One):

African American Asian Hawaii/Pacific Islander

Native American White/Caucasian Other Unknown

Ethnicity (Circle One): Hispanic Non-Hispanic

Gender (Circle One): Male Female Unknown

☐ **Consent:** I understand that I will be provide with a copy of the most current federal Vaccine Information Statement (VIS) either before or at the time of vaccination administration

Clinical Staff Only:

Date of Service: ____/____/____ **MRN For Demographic Corrections:** ____________________

Vaccine (Choose One):

❑ Fluzone quad 0.5mL (NDC Carton 49281-0423-50) (NDC Single Dose 49281-0423-88)

❑ HIGH DOSE Fluzone quad 0.7mL (NDC Carton 49281-0123-65) (NDC Single Dose 49281-0123-88)

Lot Number: ____________________________ Injection Site: Left Right

Expiration Date: _____/_____/_____ Allocation Site: ____________________________

Administered By: _______________________ Documented By: ___________________________

Adverse Reaction within first 15 min: No Yes

If Yes, Adverse Reaction Reported (Circle those that apply):

* Difficulty breathing * Hoarseness or wheezing * Swelling around the eyes or lips

* Hives * Paleness * Weakness *A fast heart beat or dizziness * Other

Notes: ____

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Data Entry Use Only:

Updates in HQ:_______ Entered in Web Tool: ________ Correction Submitted to ISD: ________