MICHIGAN STATE UNIVERSITY **Influenza Vaccine Record**

Name_____ Date of Birth_____

APID or ZPID #_____

Are you **allergic to Meds**: ◯ Yes ◯ No **Eggs**: ◯ Yes ◯ No

Chronic illnesses: _____

1. Have you had reactions to other vaccines? □ Yes □ No
2. Have you had Guillain-Barre' Syndrome? □ Yes □ No
3. Do you feel well today? □ Yes □ No
4. **Circle** if you have experienced any of the following symptoms **in the last 48 hours**: Fever or Chills, Cough, Shortness of Breath or Difficulty Breathing, Fatigue, Muscle or Body Aches, Headache, New Loss of Taste or Smell, Sore Throat, Nasal Congestion or Runny Nose, Nausea or Vomiting or Diarrhea?
5. **Are you REQUIRED to get flu vaccine for work or school? □ Yes □ No**

If YES, check appropriate box: □ MSU Healthcare Worker □ MSU CON, COM, CHM or MLS Student

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I reviewed the vaccine information sheet (VIS 08/06/21) and understand the contraindications, precautions and possible side effects of the vaccine.

Signature: _____ **Date:** _____

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☐ **Fluzone QIV** 0.5mL IM R__/__L Deltoid Sanofi Pasteur Exp. 06/30/2022

☐ LOT **# UJ685AA** ☐ LOT **# UT7330KA**

☐ **Fluarix QIV** 0.5mL IM R__/__L Deltoid GSK Exp. 06/30/2022

☐ LOT **# 7R9NM**

☐ **Fluzone High-Dose QIV** 0.7mL IM R__/__L Deltoid Sanofi Pasteur Exp. 06/30/2022

☐ LOT **# UJ709AB** ☐ LOT **# UJ709AB**

☐ **Flublok QIV** 0.5mL IM R__/__L Deltoid Sanofi Pasteur Exp. 05/27/2022

☐ LOT **# QFAA2105**

Given By: ◯ Bonnie Seaks, PA-C ◯ Pam Hang, RN ◯ Carol Piesik, PA-C