

**GRAND VALLEY
STATE UNIVERSITY®**
CAMPUS HEALTH CENTER

G#

Last Name

First Name

Birth Date

Gender

Address

City

State

Zip Code

Phone Number

GVSU Status: Faculty/Staff ☐ Student ☐ Retiree ☐ Dependent of GVSU Faculty/Staff ☐ Spouse ☐

1. Do you have an allergy to eggs? Yes ☐ No ☐
2. Are you currently ill with a fever? Yes ☐ No ☐
3. Have you ever had a severe reaction to a flu shot? Yes ☐ No ☐
4. Have you ever been diagnosed with Guillian-Barre Syndrome?
(a neurological condition that causes weakness or paralysis) Yes ☐ No ☐
5. Are you 65 or older? Yes ☐ No ☐
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I have read or have had the information about the influenza and the influenza vaccine explained to me. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and request the vaccine to be given to me or to the person named, for whom I am authorized to make this request.

Signature of Patient or Guardian

Date

Site given: Right Deltoid IM

Left Deltoid IM

Right Thigh IM

Left Thigh IM

Given by: _____

Date: _____

Payment by: Credit Card ☐ Billed to Insurance ☐

Insurance Name

Relation to Insurance Holder

Insurance Holder's Name

Insurance Holder's Date Of Birth

Address

City

State

Zip Code
