



## INFLUENZA VACCINATION REGISTRATION FORM

Name of Individual to be Immunized \_\_\_\_\_  
 Address \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  
 Medical Record Number \_\_\_\_\_

**Please answer the following questions:**

Are you sick or do you have a high fever today? Yes ☐ No ☐ Unknown ☐  
 Have you ever had an allergic reaction to a flu shot? Yes ☐ No ☐ Unknown ☐  
 Do you have an allergy to eggs? Yes ☐ No ☐ Unknown ☐

**Acknowledgement:**

1. I understand the benefits of taking flu vaccine and I acknowledge that I can make appointment with my physician to discuss about flu vaccines.
2. I understand my medical care provider may submit this immunization information for immunization registry purposes.

**Release of Liability:**

I have read and I understand the acknowledgements set forth above, and I hereby release the KAUST Health and their affiliated entities, and all of their agents, employees, trustees, and representatives, from any and all liability which may arise from the vaccination and/or from the information provided to me concerning such vaccination.

**Declaration:**

I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake the responsibility to inform you of any changes therein, immediately.

\_\_\_\_\_  
 Signature of Recipient of the Vaccination

\_\_\_\_\_  
 Date

**For Office Use Only**

Flu Vaccine Lot #: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Date: \_\_\_\_\_  
 Site of Injection: \_\_\_\_R \_\_\_\_L Deltoid \_\_\_\_\_

**Patient temperature:** \_\_\_\_\_

**Flu vaccine indication:**

- |  |   |   |
|--|---|---|
| <input type="radio"/> Age is > 65 years old        | <input type="radio"/> Health care worker            | <input type="radio"/> Pregnant  |
| <input type="radio"/> Chronic respiratory diseases | <input type="radio"/> Children (6 months - 5 years) | <input type="radio"/> Immune deficiency diseases (congenital or Acquired) |
| <input type="radio"/> Chronic CNS disorder         | <input type="radio"/> Chronic Heart disease         | <input type="radio"/> chronic renal disease                               |
| <input type="radio"/> Hajj                         | <input type="radio"/> Diabetes Mellitus             | <input type="radio"/> personal request                                    |
|  | <input type="radio"/> Other.....                    |   |