Center for Family Medicine
Bismarck
UND

701 E Rosser Ave Bismarck ND 701-751-9500

Flu Shot Information Sheet

Date of Immunization: _____

Responsible Party Name: _____

Home Address: _____

City, State, Zip: _____

BCBS Policy Holder Name: _____ **Date of Birth:** _____

BCBS Policy Number: _____

Home Phone: _____

Cell Phone: _____

Have you or any of your family members previously been a patient or received a flu shot at UND CFM?

◯ **Yes** ◯ **No**

Persons Receiving Vaccine :

				Internal Use Only		
Full Name	**Relation to Holder**	**Date of Birth**	**Gender**	**Vaccine**	**Lot Number**	**Injection Site**
			◯ Male ◯ Female	Mist / Injection		
			◯ Male ◯ Female	Mist / Injection		
			◯ Male ◯ Female	Mist / Injection		
			◯ Male ◯ Female	Mist / Injection		
			◯ Male ◯ Female	Mist / Injection		
			◯ Male ◯ Female	Mist / Injection		
			◯ Male ◯ Female	Mist / Injection		
			◯ Male ◯ Female	Mist / Injection		

VIS Sheet Given: _____
Sheet Date: _____
Nurse: _____