



515 East Broadway Avenue
Bismarck, ND 58501

Name (Please Print) Birth Date Age

Address: City State Zip

Have you received any services from UND Center for Family Medicine previously? _____

X _____
Signature (Person Receiving Vaccine or Parent/Guardian)

(For Clinic Use)

Name of Clinic: Injection Given By: _____

UND Center for Family Medicine Notes/Other Diagnoses _____

Date of Vaccination: _____

Manufacturer & Lot #: _____

Site of Injection _____

Chronic Disease: _____

Yes No

I have explained rational of flu vaccine as well as risks and limitations.

I have explained potential side effects.

I have reviewed healthy lifestyle issues with this patient including recommendations for screening tests.

Patient had opportunity to ask questions.

Comments: _____

Physician Encounter By: _____ Date: _____