Flu Shot Information

(please type or print legibly)

First Name: _____

Last Name: _____

Date of Birth: _____

Mailing Address: _____

Phone Number: _____

Insurance Information:

Member ID Number: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber Address: _____

Please circle yes or no:

1. Are you allergic to eggs?

☐ Yes ☐ No

2. Have you had a previous reaction to the flu vaccine?

☐ Yes ☐ No

***Please note:** If you answer "yes" to either question, you will not be able to receive the flu vaccine from Murray State University Health Services.