



CONSENT FORM FOR SEASONAL INFLUENZA (FLU) VACCINE

I have read or have had explained to me the information about influenza and influenza vaccine. I have had an opportunity to discuss the benefits and risks of influenza vaccine with a healthcare provider of my choice before coming here today. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to ME

Please print:

Name: _____
(FIRST) (MIDDLE) (LAST)

Date of Birth ____/____/____ & Age _____

Vaccine is for (check one): Adult

Has the person receiving the vaccine ever had a severe allergic (hypersensitivity) reaction to eggs, chickens, or chicken feathers? YES NO

Does the person receiving the vaccine have a history of Guillain-Barré syndrome or a persistent neurological illness?

YES NO

Has the person received a live vaccine within the past 30 days (i.e. MMR, RotaTeq/Rotarix)? Yes* No

**If YES, it is recommended to space live vaccines by ≥ 4 weeks for full efficacy*

Is the person receiving the vaccine pregnant? YES NO

Is the person receiving the vaccine allergic to Neomycin, Thimerosal (Preservative found in contact lens solution), any vaccine ingredient, or latex? YES NO

Signature of person receiving vaccine OR Parent/Guardian _____ Date _____

DO NOT WRITE IN THIS SPACE—OFFICE USE ONLY VIS Edition Provided: _____

Lot number: _____ Expiration Date: _____ CHECK ONE:

___ 0.5 mL IM Influenza Virus Vaccine given in ___ left ___ right deltoid – TIV or QIV

___ 0.5 mL IM Influenza HIGH Dose Virus Vaccine given in ___ left ___ right deltoid (65+) TIV-SR

___ 0.5mL Intradermal Virus Vaccine site _____ - TIV

___ 0.5mL FluBlok Influenza Virus Vaccine given in ___ left ___ right deltoid

___ Children 6-35 months: 0.25 mL/dose given in ___ left ___ right deltoid (1 or 2 doses per season)

___ Children 3-8 years: 0.5 mL/dose given in ___ left ___ right deltoid (1 or 2 doses per season)

___ Children older than 9 years: 0.5 mL/dose given in ___ left ___ right deltoid (1 dose per season)

Provider's Signature _____ Date _____ Time _____