

2017-2018 Influenza Consent Form

Name (Last, First, MI): _____

DOB: _____

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| 1. Do you have a serious allergy to eggs? | Yes | No |
| 2. Do you have any other serious allergies that you know of? | Yes | No |
| If yes, please list: _____ | | |
| 3. Have you ever had a serious reaction to the flu vaccine? | Yes | No |
| 4. Are you sick today? | Yes | No |
| 5. Have you ever had Guillain-Barre Syndrome (a type of temporary, severe muscle weakness) within 6 weeks after receiving a flu vaccine? | Yes | No |
| 6. Do you have any conditions that weaken your immune system or care for anyone with a weakened immune system? | Yes | No |
| 7. Are you taking anti-viral medicines (like Tamiflu, Relenza) or aspirin? | Yes | No |
| 8. For Children under 8 years of age: Have they had flu vaccine before? | Yes | No |
| 9. Do you have a seizure disorder or cerebral palsy? | Yes | No |
| 10. Are you pregnant? | Yes | No |
| 11. Do you have asthma or wheezing? | Yes | No |

Consent:

I have received the Vaccine information form and agree to have the Influenza vaccine administered:

Signature: _____

Vaccination Record

| Vaccine | Route | Date Administered | Dose Number (1 st or 2 nd) | Vaccine Manufacturer | Lot Number | Exp Date | Name & Title of Administrator |
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