GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

180 Park Ave, 1st Floor
Portland, Maine 04102
(207) 874-2141

2017-2018 Influenza Consent Form

Name (Last, First, MI): _____ DOB: _____

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