

CONSENT FORM FOR SEASONAL INFLUENZA (FLU) VACCINE

I've carefully reviewed the information on influenza and its vaccine. Prior to today's visit, I discussed the vaccine's pros and cons with a healthcare provider. All my questions were answered satisfactorily, and I understand both the benefits and risks. I request the vaccine for ME MY CHILD.

Please print:

Title: _____ Name: _____ Last 4 SSN: _____
(FIRST) (MIDDLE) (LAST)

Child's Birthday ____ / ____ / ____ & Age _____ (if applicable)

Is your child 6 months of age or older? YES NO (If "no," your child may not receive the vaccine at this time.)

Parent or Guardian's Name: _____

Vaccine is for (check one): Physician Contractor Employee Volunteer Family Member (Adult)

Family Member (Child) Other _____

Company/Organization: _____

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

For children 6 mo-8 yrs: Have they received 2 or more doses of influenza vaccine since July 2015? YES NO
(If no, the child will need to receive 2 vaccinations [at least one month apart] for the best protection against flu.)

For children and adolescents aged 2-17 yrs: Is the child taking long-term aspirin or aspirin-containing therapy?

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)

Nurse/ Provider's Signature

Date

Time