



**Influenza Immunization Consent Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sex (please circle): ( M / F )  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Provider: \_\_\_\_\_ ID: \_\_\_\_\_  
Group: \_\_\_\_\_ Person Code: \_\_\_\_\_

I hereby agree to allow entry of this vaccination onto the NYS Immunization registry.  
 Yes  No

**Please complete the questions below:**

- Yes  No Are you currently sick or do you have a fever?
- Yes  No Have you ever had an allergy to any component (or part) of the flu vaccine?  
If yes, please describe:
- Yes  No Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving flu vaccine?
- Yes  No Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease? If yes, please describe:
- Yes  No Are you allergic to eggs or egg products?
- Yes  No Are you currently pregnant?
- Yes  No Are you taking blood-thinning medication?
- Yes  No Do you have a weakened immune system or have close contact with a person with an extremely weakened immune system who needs special care?
- Yes  No Have you received any other vaccinations within the last 4 weeks?
- Yes  No Have you taken an antiviral medication for the flu within the last 48 hours?

**Influenza Consent**

I have read, or had explained to me, the Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccination be given to me. I authorize the release of any medical or other information necessary to process a Medicare of other insurance claim or for other public health purpose.

Signature of Recipient \_\_\_\_\_

Date \_\_\_\_\_

**Area Below To be Completed By Pharmacist**

Administration Date: \_\_\_\_\_  
Administration Site:  LD  RD  LT  RT  
Manufacturer & Lot #: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
VIS Date: \_\_\_\_\_  
Administered By: \_\_\_\_\_