Influenza Vaccination Consent Form

BREEN FAMILY MEDICINE

Patient Information:

Last Name: _____ First Name: _____ Date of Birth: _____

Screening for influenza vaccine eligibility

1. Do you have a severe allergy to eggs? ☐ Yes ☐ No
2. Have you ever had a life-threatening reaction to the influenza vaccine? ☐ Yes ☐ No
3. Do you have a history of Guillain-Barre Syndrome? ☐ Yes ☐ No
4. Are you moderately or severely ill today? ☐ Yes ☐ No

If yes to any questions 1-3 then DO NOT vaccinate with influenza vaccine. If yes to question 4, vaccinate when resident has recovered.

I have read or had explained to me the Vaccination Information Statement about influenza vaccination and I understand the benefits and risks of influenza vaccination. I request that the influenza vaccination be given to me (or the person named above for whom I am authorized to make this request).

Signature: _____ Date: _____

Name (print or type): _____

Relationship to Patient : _____

To be completed by person administering vaccine

Today's Date: _____ Flu Season Dates: 20 20 - 20 21

Site of Injection: ☐ R ☐ L Administered by: _____

Lot Number: _____ Expiration Date: _____