**Influenza Vaccination Consent Form**

*Patient information*

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

**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-Bare 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 patient 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 the influenza vaccine to be given to me or the person named above for whom I am authorized to make this request.

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Provider signature/Date Patient or Responsible Party Signature/Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Printed Name Patient or Responsible Party Printed Name