CONSENT FORM FOR SEASONAL INFLUENZA VACCINE

I have read or have had explained to me the information about influenza and influenza vaccine. I have had an opportunity to discuss the benefits and risks of influenza vaccine with a healthcare provider of my choice before coming here today. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to ME/ MY CHILD. (circle one)

Please print:

Title: _____ **Name:** _____ **3/4 ID or 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 (circle one): Physician Employee Contractor 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

Is the person receiving the vaccine pregnant? ____Yes ____No (If yes, LAIV contraindicated, TIV recommended)

Is the person receiving the vaccine allergic to Thimerosal (Preservative found in contact lens solution), any vaccine ingredient, or latex? ____Yes ____No

For child 6 mo-8 yrs, have they received 2 or more doses of influenza vaccine since July 2010? ___Yes___No
(If no, the child will need to receive 2 vaccinations [at least one month apart] for the best protection against flu.)

_____ _____
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
___ 0.2 mL Live Attenuated Influenza Virus Vaccine given intranasally (half each nostril)
___ 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

Place Employee Info label here, if desired