Influenza Vaccine Consent Form – Flu Season 2023-24

First Name_______________________________ Last Name_________________________DOB____________

Address____

City____State_____________Zip Code_____________________

Male____Female_____Phone Number_____________________Email:_________________________________

Insurance______________________________ID#____________________________Group________________

	NO	YES
Are you feeling sick today?		
Have you ever had an allergic reaction to a vaccine?		
Are you allergic to: Chicken, eggs, egg products, Thimerosa in vaccine, Gentamycin or Latex		
Do you have a bleeding disorder?		
Are you taking any medication that could affect blood clotting?		
Are you being treated for cancer, HIV/AIDS or any disease that weakens your immune system		
Have you ever been diagnosed with Guillain-Barre Syndrome?		
Have you received any vaccinations in the past month?		
If female, are you pregnant or may become so next month?		

Please explain any "YES" answers provided above:____

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I have received a copy of the Vaccine Information Statement (VIS) Yes_______ VIS Date_________________

CONSENT and WAIVER: I consent to the staff to administer influenza vaccine. I have received the vaccine information sheet(s) and understand the benefits and risks of receiving this medication and assume this risk. I fully release and discharge the health care facility, its affiliation and their officers and employees from any illness, injury, loss or damage that may result there from. I assign payment of authorized insurance benefits due to me to be paid to the organization and will pay any copay or deductible that result. I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. I also allow for the organization to report any medications received to the appropriate state vaccine registry.

Signature of patient___________________________Relation to patient__________________Date__________

Injection Site Right____ Left____ Deltoid Primary Care Provider__________________________________