2020 - 2021 INFLUENZA VACCINE CONSENT FORM

First Name:____________________ **Last Name:** ____________________ **Date:** ____________

Complete Address:____

DOB:_______________ **Gender:**____________________

1) Have you/your child ever had an allergic reaction to a flu vaccine? Yes No
2) Are you/your child allergic to eggs or egg products? Yes No
3) Do you/your child have a history of Guillain-Barre' Syndrome*? Yes No
   *Weakness beginning in the feet and hands and migrating towards the trunk.
4) Are you/your child allergic to latex? Yes No
5) Do you/your child feel ill today or have a fever? Yes No
6) Are you/your child currently pregnant? Yes No

If younger than 8 years of age, how many flu shots has the child received in theirlifetime?

☐ 0 shots ☐ 1 shot ☐ 2 shots or more

**It is recommended by the CDC that children younger than 8 years old who have received 1 or less flu shots, receive a second dose at least 28 days after the first dose to optimize response.*

I/My child have been offered the Influenza Vaccine to protect against seasonal influenza. I/My child have received a copy of the **Vaccine Information Statement (VIS) and have read and/or had explained the information therein.**

☐ Upon this offering, I have chosen to receive the vaccine or I am consenting for my child to receive the vaccine. I attest that the above information is correct.

Patient or Parent/Guardian Signature:____________________ Date: __________

***For Internal Use Only**

Date Administered:		**Client:**	
Vaccine Manufacturer: (circle one)	Sanofi - Fluzone	**Location of Clinic or Flu Clinic:**	
Dose:	0.5 mL		
Exp. Date/Lot Number:			
Site Injection Given: IM	**RIGHT** Deltoid	**LEFT** Deltoid	**Other** __________
VIS Given:	Yes	Date of VIS: 8/15/2019	
Administered by:			
Clinical Double Check:	Signature:		

Clinician consult and signature is required to proceed with immunization if “Yes” was on any of the above questions.

Reviewed by:____________________________ Date: ______________