

CONSENT FORM FOR SEASONAL INFLUENZA (FLU) 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. 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.

Please print:

Name: _____
 (FIRST) (MIDDLE) (LAST)

Birthdate: ___ / ___ / ___

Vaccine is for (check one): Patient Physician Contractor Employee Volunteer

Company/Organization: _____

Has the person receiving the vaccine ever had a severe allergic (hypersensitivity) reaction to eggs, chickens, or chicken feathers? **If YES, Flublok does not contain any egg proteins.*

YES NO

Does the person receiving the vaccine have a history of Guillain-Barré syndrome or a persistent neurological illness?

YES NO

Has the person received a live vaccine within the past 30 days (i.e. MMR, RotaTeq/Rotarix)? Yes* No

**If YES, it is recommended to space live vaccines by \geq 4 weeks for full efficacy*

Is the person receiving the vaccine pregnant? YES NO

Is the person receiving the vaccine allergic to Neomycin, Thimerosal (Preservative found in contact lens solution), any vaccine ingredient, or latex? YES NO

For staff: Has the person receiving the vaccine completed the pre-consent in K-Health? YES NO

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 **Fluzone** Influenza Trivalent Virus Vaccine given in ___ left ___ right deltoid ___
 ___ 0.5mL IM **Flublok** Trivalent (EGG FREE) Influenza Virus Vaccine given in ___ left ___ right deltoid

 Nurse/ Provider's Signature _____ **Date** _____ **Time**

