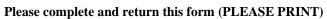
Influenza Vaccination Consent Form and Record (2022-2023 Flu Season)





	PERSONAL IN	FORMATION:								
		ENT NAME:								
	DATE OF BIRTH: Phone #									
	ADDRESS:									
	ADDR	ESS:								
	PCP:									
Please circle Yes or No to each question below:										
1.	Are you currently sick with a fever, vomiting or diarrhe	a?		Yes	No					
2.	2. Are you severely allergic to eggs, egg proteins, thimerosal, neomycin, polymyxin or to another component of influenza?									
3.										
4.	4. Have you ever had Guillain-Barre syndrome?									
5.	5. Are you Latex allergic?									
6.	6. Do you have an immunocompromising condition (e.g. cancer, leukemia, lymphoma, HIV/AIDS, transplant) functional, or anatomic asplenia, CSF leak or cochlear implant or take a medication (e.g., steroids or chemotherapy) that lowers the body's resistance to infection?									
7.	7. Do you have asthma or recurrent or active wheezing?									
8.	8. Are you pregnant or nursing?									
9. Please let us know if you have close contact with anyone who has a weakened immune system and must be in a protective environment (eg, an individual who has had a bone marrow transplant). Please describe:										
10. Have you received a vaccine within the past 30 days?										
If yes, please list name of vaccine(s): Dates: 11. If you are < 9 years old, have you had at least 2 flu shots in your lifetime?										
12. If you are < 18 years old, is your parent or guardian present or available by phone to get consent?										
13. If you are >/ 65 years old, do you prefer to receive the high dose if available? CDC has no opinion.										
v v / v x										
	If you answered YES to Q 1-4 you should <u>NOT</u> receive a gh 10, you should <u>NOT</u> receive an intranasal vaccine, but									
and ha consen success admin	been given the Centers for Disease Control and Preventical ave no further questions at this time. I understand the risk at to receiving the influenza vaccine and I acknowledge the s. I understand the possible side effects and warnings and istration of the vaccine and consent to emergency treatment ies or medical alert:	as and benefits of the vaccine. I requate at no guarantees have been made con precautions that should be taken in ent if needed.	est and volumer the	ntarily vaccin	e's					
Patien	t or Guardian Signature:		Date:							
Printe	d name of above:									
For Clinic Use Only										
Vaccino		•	Site/Route	Do	sage Vol					

For Clinic Use Only											
<u>Vaccine</u>	<u>Manufacturer</u>	VIS Date	<u>Lot #</u>	Exp Date	Site/Route	Dosage Vol					
afluria Quadrivalent	Seqirus, Inc	08/06/21			LD RD IM	0.5 mL					
Fluad Quad HIGH DOSE	Sequirus Inc	08/06/21			LD RD IM	0.5mL pfs					
Signature of Vaccine A	Administrator:		Administration Date:								