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

Please complete and return this form (PLEASE PRINT)

Aston Pharmacy
Home Health Center
"Where caring is the heart of our business"

PERSONAL INFORMATION:	
	PATIENT NAME:
	DATE OF BIRTH: **Phone #**
	ADDRESS:
	PCP:

Please circle Yes or No to each question below:	
1. Are you currently sick with a fever, vomiting or diarrhea?	**Yes No**
2. Are you severely allergic to eggs, egg proteins, thimerosal, neomycin, polymyxin or to another component of influenza?	**Yes No**
3. Have you ever had a serious reaction to an influenza vaccine?	**Yes No**
4. Have you ever had Guillain-Barŕe syndrome?	**Yes No**
5. Are you Latex allergic?	**Yes No**
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?	**Yes No**
7. Do you have asthma or recurrent or active wheezing?	**Yes No**
8. Are you pregnant or nursing?	**Yes No**
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:_____	**Yes No**
10. Have you received a vaccine within the past 30 days? If yes, please list name of vaccine(s): _____ Dates: _____	**Yes No**
11. If you are < 9 years old, have you had at least 2 flu shots in your lifetime?	**Yes No**
12. If you are < 18 years old, is your parent or guardian present or available by phone to get consent?	**Yes No**
13. If you are >/ 65 years old, do you prefer to receive the high dose if available? CDC has no opinion.	**Yes No**

Note: If you answered YES to Q 1- 4 you should <u>NOT</u> receive an influenza vaccine. If you answered YES or left blank Q 6 through 10, you should <u>NOT</u> receive an intranasal vaccine, but it is recommended to receive an injectable influenza vaccine.

I have been given the Centers for Disease Control and Prevention Vaccine Information Sheets. I have read these documents and have no further questions at this time. I understand the risks and benefits of the vaccine. I request and voluntarily consent to receiving the influenza vaccine and I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the possible side effects and warnings and precautions that should be taken into consideration prior to administration of the vaccine and consent to emergency treatment if needed.

Allergies or medical alert: _____

Patient or Guardian Signature: _____ Date: _____

Printed name of above: _____

For Clinic Use Only

Vaccine	Manufacturer	VIS Date	Lot #	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 Administrator: _____ Administration Date: _____