Influenza Vaccination Consent Form and Record
(2024-2025 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:
	Primary Physician:

Please circle Yes or No to each question below:

1 – 1.B HIGH DOSE VACCINE QUESTIONS ONLY		
1. Are you 65 years or older, and do you prefer to receive the HIGH DOSE vaccine if available? The CDC has no opinion. If yes, please answer the following HIGH DOSE questions.	Yes	No
1.a. Are you severely allergic to eggs, egg proteins? *If yes, avoid HIGH DOSE.	Yes	No
1.b. Are you severely allergic to Thimerosal / Neomycin / Kanamycin / Hydrocortisone Formaldehyde or any other component of influenza? *If yes, avoid HIGH DOSE.	Yes	No
2. If you are < 18 years old, is your parent or guardian present or available by phone to get consent?	Yes	No
3. Are you currently sick with a fever, vomiting or diarrhea?	Yes	No
4. Have you ever had a serious reaction to an influenza vaccine?	Yes	No
5. Have you ever had Guillain-Barŕe syndrome?	Yes	No
6. Are you Latex allergic?	Yes	No
7. 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
8. Do you have asthma or recurrent or active wheezing?	Yes	No
9. Are you pregnant or nursing?	Yes	No
10. Please let us know if you have close contact with anyone who has a weekend immune system and must be in a Protective environment (eg. An individual who has had a bone marrow transplant). Please describe: _____	Yes	No
11. Have you received a vaccine within the past 30 days? If yes, please list name of vaccine(s): _____ Dates: _____	Yes	No

Note: If you answered YES to Q 1.A or 1.B you should NOT receive a HIGH DOSE influenza vaccine. If you answered YES to Q 3 - 5 you should NOT receive an 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
☐ Flucelvax Quadrivalent	Seqirus, Inc	08/06/21	388518	06/04/25	LD RD IM	0.5 mL pfs
☐ Fluad Quad **HIGH DOSE**	Seqirus Inc	08/06/21	388493	04/30/25	LD RD IM	0.5mL pfs

Signature of Vaccine Administrator: _____ **Administration Date:** _____

For office use only: ____Billed ____Scanned ____PA SIIS ____Faxed Doctor 08/29/2024