Rye Beach Pharmacy
464 Forest Ave, Rye NY 10580
914-967-0856

INFLUENZA VACCINE (FLU SHOT) CONSENT FORM

Please choose the vaccine you want: ***(both are preservative free)***

☐ **Influenza Quadrivalent Vaccine:** ***(Ages 5 and up)***

☐ **Hi-Dose Influenza Quadrivalent Vaccine:** ***(Adults 65 years & older)***

1. **Have you ever had an allergic reaction to flu vaccine?** **Yes or No**
2. **Are you allergic to eggs, or egg products?** **Yes or No**
3. **Are you allergic to Neomycin or Polymyxin** **Yes or No**
4. **Do you have a history of Guillain-Barre Syndrome?** **Yes or No**

(illness associated with the swine flu in 1976 characterized by fever, nerve damage, and muscle weakness)

5. **Are you allergic to latex?** **Yes or No**
6. **Do you feel ill today, or do you have a fever?** **Yes or No**
7. **If you are female, are you pregnant? # Weeks_____** **Yes or No**
8. **Which arm would you prefer to receive your vaccine? (recommend using non-dominant arm)**

Right or Left

I hereby certify that the foregoing history is true and complete to the best of my knowledge and I have received and read the "Vaccine Information Statement" from the CDC, have had an opportunity to ask questions that were answered to my satisfaction, and do wish to receive the flu vaccination fully understanding the risks and the benefits. I hereby consent to the administration of the flu vaccine (flu shot). I allow Rye Beach Pharmacy to notify my primary care physician, as well as the required NY State Regional Immunization Information System (NY RIIS) of the vaccination I receive today.

PARTICIPANT INFORMATION AND CONSENT

LAST NAME:	**FIRST NAME:**		**MI:**
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHONE:	**E-MAIL:**		
BIRTHDATE:	**AGE:**		
PRIMARY CARE PHYSICIAN:	**ADDRESS OF PHYSICIAN:**		
SIGNATURE:	**DATE:**		

FOR PHARMACY USE ONLY

MANUFACTURER AND LOT#:
EXPIRATION DATE:
SITE OF INJECTION: R / L DELTOID
SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR:

VIS dated 8/15/19 given on _____