

FLU VACCINE CONSENT AND ADMINISTRATION FORM

Last Name:_____ First Name:_____

Date of Birth: (MM/DD/YYYY):_____ Phone:_____

Address:_____

Please circle the answers to the following questions:

- | | | |
|--|-----|----|
| 1. Is the person being vaccinated sick today? | yes | no |
| 2. Has the person being vaccinated ever had an allergic reaction to the influenza (Flu) vaccine? | yes | no |
| 3. Has the person being vaccinated been told they are allergic to one of the ingredients in the Flu vaccine? | yes | no |
| 4. Does the person being vaccinated have a personal or family history of Guillain-Barre syndrome? | yes | no |

CONSENT:

I hereby certify that the above information about myself or my dependent is true and complete to the best of my knowledge. I have been given the opportunity to read the "Vaccine Information Statement" for the Influenza vaccine, have had the opportunity to ask questions that were answered to my satisfaction, and wish to receive the Flu vaccine fully understanding the risks and the benefits of the vaccine. I hereby consent to the administration of the influenza vaccine (Flu vaccine) to me or my dependent.

Signature of Recipient or Parent/Guardian

Date

Clinic Use Only:

☐ Standard dose

☐ High Dose ≥ 65 years old

IM Injection:

☐ Left Deltoid

☐ Right Deltoid

Lot/Exp:_____

Administrator:_____