2024-2025 INFLUENZA 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:

- ☐ Fluzone
- ☐ Fluarx
- ☐ Flucelvax
- ☐ High Dose Fluzone

IM Injection:

- ☐ Left Deltoid
- ☐ Right Deltoid

Administrator:_____

Lot:_____

Expiration Date:_____