PATIENT CONSENT FORM

FOR SEASONAL INFLUENZA VACCINE

I have read, or have had explained to me, the CDC Vaccine Information Statement about influenza and the influenza vaccine. I understand that this vaccine may cause flu-like symptoms in some people and in rare incidents Guillain-Barré syndrome. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me (or person named below for whom I am authorized to make this request).

Please print:

Name:_____ Date OF Birth:_____

Address_____ Phone #_____

Zip code :

Primary Care Doctor_____

Has the person receiving the vaccine ever had a severe allergic (hypersensitivity) reaction to eggs, chickens, or chicken feathers? ____Yes ____No

Does the person receiving the vaccine have a history of Guillain-Barré syndrome or a persistent neurological illness? ____Yes ____No

Is the person receiving the vaccine pregnant? ____Yes ____No (If yes, LAIV contraindicated, TIV recommended)

Is the person receiving the vaccine allergic to Thimerosal (Preservative found in contact lens solution), any vaccine ingredient, or latex? ____Yes ____No

For child 6 mo-8 yrs, have they received 2 or more doses of influenza vaccine since July 2010? ___Yes___No
(If no, the child will need to receive 2 vaccinations [at least one month apart] for the best protection against flu.)

_____ _____

Signature of person receiving vaccine OR Parent/Guardian **Date**

DO NOT WRITE IN THIS SPACE—OFFICE USE ONLY VIS Edition Provided: _____

Lot number: _____ Expiration Date: _____ Dose #1 or Dose #2

_____ _____ _____

Nurse/MA/Provider's Signature Date Time