



Changing Health Care for Good®

INFLUENZA VACCINE CONSENT 2020-2021 SEASON

PRINT PATIENT'S NAME: _____ DOB: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Is the person receiving the vaccine allergic to chicken protein, eggs, or egg products?

(ex: hives, swelling of lips or acute respiratory distress or collapse)

Yes No

2. Has the person receiving the vaccine previously had a serious reaction to the flu vaccine?

Yes No

3. Is the person receiving the vaccine presently ill and/or have a fever?

Yes No

4. Is the person receiving the vaccine now or think they may be pregnant?

Yes No

If you answered YES to any of the above questions, you should not receive the vaccine without consulting a physician

Provider Notes if Applicable _____

WARNING

The Flu shot should not be given to people with a severe allergy (ex. anaphylaxis, hives, respiratory distress or collapse) to eggs or chicken protein.

POSSIBLE SIDE EFFECTS

Most common: Slight Swelling and tenderness at the injection site. This may last 24-48 hours. Fever or body aches lasting 1-2 days, especially in persons not previously exposed to the flu virus. NOTE: Because Influenza vaccine contains only noninfectious viruses, it cannot cause active Influenza, "the flu".

Unlike 1979 Swine Flu Vaccine, recent flu vaccines have not been clearly linked to the paralytic illness Guillain-Barre Syndrome. On very rare occasions, GBS may occur in the days or weeks after getting a vaccination.

I have read the Influenza Vaccine Information Statement (VIS) and had the information explained to me about influenza and the influenza vaccine. I have had a chance to ask questions and they have been answered to my satisfaction. I understand the benefits and risks of the influenza vaccine, and request that the vaccine be given to me or the person named above for whom I am authorized to make this request.

Patient Signature _____ Date _____

Or Parent/Legal Guardian _____ Date _____

FOR OFFICE USE ONLY

Vaccine Type/Brand: _____ Dose: _____ mL

[AFFIX LABEL HERE]

LOT _____ Expiration _____

IM Injection Administered:

Circle Location: Right Deltoid / Left Deltoid

Administered by: _____

Pediatric (birth-2yr) Right Vastus Lateralis / Left Vastus Lateralis

NAME/CREDENTIAL (printed)

Reactions noted after vaccine given No _____ Yes _____ (If yes, notify the provider and document in EMR)