



## Flu Vaccine Consent Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Male

Female

**Please answer the following questions:**

- 1 Are you sick or do you have a high fever today?  
(If yes, you should not receive vaccine)
- 2 Have you been sick in the past two weeks?
- 3 Are you allergic to chicken, eggs, or egg products?
- 4 Have you ever had an allergic reaction to a flu shot?
- 5 Are you pregnant, or think you may be?
- 6 Do you have a blood clotting disorder or are you taking  
blood thinning medication?

Yes	No	Unknown

### CONSENT AND RELEASE STATEMENT

I, THE UNDERSIGNED, WISH TO RECEIVE A VACCINATION AGAINST INFLUENZA. I AM TAKING THIS VACCINE VOLUNTARILY AND CONSENT TO THE VACCINATION BEING GIVEN TO ME. I HAVE READ THE PROVIDED INFORMATION OR HAVE HAD SUCH EXPLAINED TO ME. I UNDERSTAND THE RISKS AND BENEFITS OF THIS VACCINE. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS WHICH HAVE BEEN ANSWERED TO MY SATISFACTION. I HEREBY REQUEST THAT THE VACCINE BE GIVEN TO ME OR TO THE PERSON NAMED ABOVE FOR WHOM I AM AUTHORIZED TO MAKE THIS REQUEST.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

FOR OFFICE USE ONLY					
Date Given	Manufacturer & Lot No.	Exp. Date	Site (circle)	Route	Administered By:
			RD            RT LD            LT		