Ver 10-6-21

Northeast District Department of Health

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Inactivated Influenza Immunization Consent Form

The following questions will help us determine if there is reason we should not give you inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is unclear, please ask your provider to explain it.

Name (First, Mi, Last): _____ **Date**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Date of Birth: _____ **Primary Phone**: _____-_____-_____

Answer the questions below:	(Circle one:)	
1. Is this your first time EVER getting a flu shot?	No	Yes
2. Do you have allergies to medications, eggs, or a vaccine component?	No	Yes
3. Have you ever had a serious reaction to the flu shot?	No	Yes
4. Have you ever had Guillain-Barre Syndrome? (A neurological condition)	No	Yes
5. Do you have a bleeding disorder?	No	Yes
6. Are you sick today?	No	Yes

INFLUENZA CONSENT:

I have read, or had explained to me, the information sheet* about influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that the flu vaccination be given to me (or the person named above for whom I am authorized to make this request).

Notice of Privacy Practices information sheet is available upon request.

X_____
Signature of recipient (or parent or guardian)

***Vaccine Information Statement (VIS) 08/06/21 (most current)**

INFLUENZA ADMINISTRATION – For Office Use Only

Injection Site: □ Left Arm □ Right arm □ Other _____

Manufacturer: _____ Lot # _____ Exp: _____

_____ ____/____/____
Nurse Signature Date