

Administration of the Flu Vaccine Consent Form

Medicare _____
Senior HMO _____
Other: _____

Name: _____ D.O.B. _____ Doctor: _____

For patients: Please read the Vaccine Information Statement and answer the following questions. Due to the possibility of an allergic reaction, we are requesting that you wait 10 minutes after you receive the vaccine injection.

1. Have you ever had an allergic reaction to the influenza vaccine?
YES _____ NO _____

2. Have you received the flu vaccine in the last 6 months?
YES _____ NO _____

3. Have you been ill or run a temperature in the last 48 hours?
YES _____ NO _____

4. Do you have a history of Guillain-Barre Syndrome?
YES _____ NO _____

5. Are you pregnant?
YES _____ NO _____

6. Did you read and understand the "Vaccine Information Statement"?
YES _____ NO _____

7. Do you have any questions?
YES _____ NO _____

If you answered YES, please list your question(s): _____

8. I will remain in the office for 10 minutes for observation.
YES _____ NO _____

I AM AWARE THIS IMMUNIZATION COULD BE A NON-COVERED SERVICE

Patient Signature Date

If the patient answers YES to questions 1-5, a physician MUST be consulted.

Patient temperature (if indicated): _____

Immunize with the 2020 – 2021 Flu Vaccine 0.5 ml (IM): R Deltoid L Deltoid

Lot # label here:

Mfg: _____ Lot#: _____ Exp. Date: _____

Administered By Signature Date