2020-2021 HIGH DOSE INFLUENZA VACCINE CONSENT FORM

(for age 65 years and older)

First Name:____________________ **Last Name:** ____________________ **Date:** ______________

Complete Address:____

DOB:________________ **Gender:**__________________________

1) Have you ever had an allergic reaction to a flu vaccine?	Yes	No
2) Are you allergic to eggs or egg products?	Yes	No
3) Do you have a history of Guillain-Barre' Syndrome*? *Weakness beginning in the feet and hands and migrating towards the trunk.	Yes	No
4) Are you allergic to latex?	Yes	No
5) Do you feel ill today or have a fever?	Yes	No
6) Are you UNDER age 65?	Yes	No

I have been offered the High Dose Influenza Vaccine to protect against seasonal influenza. I have received a copy of the **Vaccine Information Statement (VIS) and have read and/or had explained the information therein.**

☐ Upon this offering, I have chosen to and consent to receive the vaccine. I attest that the above information is correct.

Patient or Guardian Signature: ______________________________ Date: ______________

***For Internal Use Only**

Date Administered:		**Client:**	
Vaccine Manufacturer: (circle one)	Sanofi - High Dose Fluzone	**Location of Clinic or Flu Clinic:**	
Dose:	0.7 mL		
Exp. Date/Lot Number:			
Site Injection Given: IM	**RIGHT Deltoid**	**LEFT Deltoid**	**Other** ____________________
VIS Given:	Yes	Date of VIS: 8/15/2019	
Administered by:			
Clinical Double Check:	Signature:		

Clinician consult and signature is required to proceed with immunization if “Yes” was on any of the above questions.

Reviewed by:______________________________ Date: ____________________