



**2020 - 2021 INFLUENZA
VACCINE CONSENT FORM**



First Name: _____ Last Name: _____ Date: _____

Complete Address: _____

DOB: _____ Gender: _____

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

If younger than 8 years of age, how many flu shots has the child received in their lifetime?

- 0 shots
- 1 shot
- 2 shots or more

**It is recommended by the CDC that children younger than 8 years old who have received 1 or less flu shots, receive a second dose at least 28 days after the first dose to optimize response.*

I/My child have been offered the Influenza Vaccine to protect against seasonal influenza. I/My child 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 receive the vaccine or I am consenting for my child to receive the vaccine. I attest that the above information is correct.

Patient or Parent/Guardian Signature: _____ Date: _____

***For Internal Use Only**

Date Administered:		Client:	
Vaccine Manufacturer: (circle one)	Sanofi - Fluzone	Location of Clinic or Flu Clinic:	
Dose:	0.5 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: _____