



INFLUENZA VACCINE CONSENT FORM

WARNING:

Some persons should not take influenza vaccine without checking with a clinician.

- I do not have fever or significant illness.
- I have never had a severe allergic reaction to the flu vaccine or to its components.
- I have never had Guillain Barre Syndrome.

I have read the Vaccine Information Statement for Inactivated Flu Vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and request that it is given to me or to the person named below for who I am authorized to make this request.

Information on Person to Receive Vaccine

For Health Center Use ONLY

NAME (Please Print)	BIRTHDATE	AGE	RECORD VERSION OF VIS (Year): 08/07/2015
HEALTH INSURANCE CARRIER <input type="checkbox"/> Cigna <input type="checkbox"/> Other _____ SUBSCRIBER: <input type="checkbox"/> Self <input type="checkbox"/> Other, if other: Subscriber Name: _____ Subscriber Date of Birth: _____ Relationship: _____			DATE & TIME VACCINATED
HEALTH INSURANCE ID NUMBER			MANUFACTURER/EXPDATE/LOT#
<input type="checkbox"/> HRA <input type="checkbox"/> H.S.A. <input type="checkbox"/> Other: _____			
ADDRESS			
CITY / STATE/ ZIP CODE			IM injection site: LD RD LV RV
ALLERGIES			
PRIMARY LANGUAGE			
ETHNICITY <input type="checkbox"/> Hispanic/Latino/Spanish Origin <input type="checkbox"/> No Hispanic/Latino/Spanish Origin <input type="checkbox"/> Unknown			
RACE <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Declined			
X SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE CONSENT			GIVEN BY:

SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE CONSENT

DATE