Patient Label if Available

Name_____

Date of Birth _____/_____/_____

Chart ID_____

SEASONAL INFLUENZA VACCINE CONSENT FORM

2020-2021

General Health Questions

Please notify your provider if you have any of the following:

- Previous severe reaction to influenza vaccine
- History of Guillain-Barre Syndrome within 6 weeks of a flu vaccine
- Acute febrile illness
- Previous influenza immunization this flu season
- A severe allergy to a component of the vaccine, which may include:
  - Fluad - egg protein, formaldehyde, neomycin, kanamycin, CTAB
  - Flucelvax - Thimersol
  - Flublok - none

I have read (or it has been read to me) and I understand the "Seasonal Influenza Vaccine Information Sheet".
I have had the opportunity to ask questions and to have them answered to my satisfaction.
I consent to the seasonal influenza vaccine.

If signing for someone other than yourself, indicate your relationship to that other person: _____

If signing for someone other than myself, I confirm that I am the parent / legal guardian or substitute decision maker.

Signature**:** _____Date of signature: _____

Please check if you do not want your information released to another health care provider. ❒

For Clinic Use Only:

VACCINE	DOSE	LOT NUMBER	EXPIRY DATE	SITE / IM	TIME GIVEN	DATE GIVEN	GIVEN BY
	0.5 ml						

Comments: _____

_____

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Revised September 1, 2020

MADISON MEDICAL