CONSENT FOR INFLUENZA VACCINE ADMINISTRATION

PATIENT NAME:____ DOB:________________________

Screening Questions for Contraindications to Inactivated Injectable Influenza Vaccination

Answer the following Screening Questions if you would like to receive the influenza vaccine.

1. Is the person to vaccinated sick today? ____ yes ____no
2. Does the person being vaccinated have any allergy to eggs or to a component of the vaccine? ____ yes ____no
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? ____ yes ____no
4. Has the person to be vaccinated ever had Guillain-Barre' Syndrome? ____ yes ____no
5. Is the person to be vaccinated pregnant? ____ yes ____no

By signing below, I agree to have the influenza vaccine administered. I have had an opportunity to ask my healthcare provider any questions I may have regarding the vaccine.

Parent/Guardian Signature:____ Today's Date:__________________

__________***********THIS SECTION TO BE FILLED OUT BY CLINIC****************_______________**

Lot#/Expiration :__________________________________

Manufacturer: ___________________________________ NDC#_________________________________

Site:__________________________________

Administered by:_____________________________________ Date:_____________________________

8/20/2020