Influenza/Pneumococcal Vaccination Consent Form

Name (please print):	Date of Birth:	Polyclinic Provider:	MRN:

☐ No ☐ Yes 1. Are you currently sick with fever?

☐ No ☐ Yes 2. Have you ever had a life threatening allergy to any component (or part) of the influenza or pneumonia vaccine? If yes, please describe:_____

☐ No ☐ Yes 3. Have you ever developed Guillain- Barré Syndrome within 6 weeks of receiving the influenza vaccine?

☐ No ☐ Yes 4. Have you ever had a severe, life threatening allergy to EGGS or EGG product?

☐ No ☐ Yes 5. Are you currently pregnant/might you become pregnant in the next month?

☐ No ☐ Yes 6. Are you 65 years or older?

Influenza Consent

I have read, or had explained to me, the Vaccine Information Statement about **influenza** vaccine.
I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccine as described. I request that the **influenza** vaccine be given to me (or the person named above for whom I am authorized to make this request).
I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

_____

Signature of Recipient or Legal Guardian Date

Influenza Vaccine

☐ Left Arm ☐ Right Arm

Dosage: ☒ 0.5ml

Manufacturer & Lot #:

VIS Date: 08/15/2019

Nurse or MA Signature: Date:

Next Influenza Vaccination is Due: ☒ Next Year