

## Flu Consent 2024-2025

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

1. Is the person to be vaccinated sick today or had a fever of greater than 100.4°F in the last 24 hours?  
 Y  N
2. Does the person to be vaccinated have an allergy to latex, mercury, thimerosal, gelatin, chicken eggs/feathers, or other vaccine components?  Y  N
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?  Y  N
4. Has the person to be vaccinated ever had Guillain-Barre Syndrome or any other neurological diseases?  
 Y  N

I have been given a copy and have read or have had explained to me the U.S. Public Health Service important information statement about influenza vaccine dated 8/6/2021. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the risks and benefits of the vaccine and agree to receive the vaccination.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Printed Name: \_\_\_\_\_

*If any above questions are answered "yes", must have provider approval and documentation*

### *Internal Use Only*

NDC#: \_\_\_\_\_

Exp: \_\_\_\_\_

Vaccine Manufacturer: \_\_\_\_\_

Vaccine Type:  Fluzone (egg-based)

Administered by: \_\_\_\_\_

Date: \_\_\_\_\_

Administration Site:  LD  RD