



# Vaccine Questionnaire & Consent for Inactivated Injectable Influenza Vaccination

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

Date of Birth: \_\_\_\_\_

If "Yes" to any of the below, consult a provider before receiving a vaccine:

- 1. Is the person to be vaccinated sick today? Yes or No
- 2. Does the person to be vaccinated have an allergy to a component of the vaccine (including eggs\*)? Yes or No  
\* CDC and ACIP no longer consider egg allergy to be a contraindication
- 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? Yes or No
- 4. Has the person to be vaccinated ever had Guillain-Barre Syndrome? Yes or No
- 5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a vaccine; or are they anxious about getting the shot today? Yes or No
- 6. Is the person 65 years of age or older and would like to receive the enhanced vaccine dose for persons 65+? Yes or No

**If person to be vaccinated is 8 years old or younger and receiving the influenza vaccine for the first time, a booster vaccine should be administered in 4 weeks. Please schedule the booster before leaving your appointment today.**

By signing below, I hereby certify that:

- My answers to the above questionnaire are true and complete to the best of my knowledge.
- I have had an opportunity to ask Marathon health center staff questions about the risks and benefits of the inactivated influenza vaccine, and my questions have been answered to my satisfaction.
- I have read or had explained to me the CDC's "Inactivated Influenza Vaccine Information Statement".
- I will follow-up with my healthcare provider with any concerns.

**I understand the risks and benefits of the inactivated influenza vaccine I have chosen to receive, and hereby give consent to Marathon Health and its staff to administer the inactivated influenza vaccine to me.** I understand I have been advised to wait 15 minutes after receiving the vaccine for my safety. If the person receiving the vaccine is under a legal guardianship, the legal guardian must sign below to confirm his or her consent to the administration of vaccine to the patient.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date

**Marathon Health Teammates:** Use the area below to document the proper procedure for charting and dispensing.

Charted:

Affix vaccine sticker(s):

Dispensed from inventory:

*If unable to chart/dispense at time of administration, capture below information and update systems accordingly when available:*

Site of injection: R / L deltoid

Signature of administrator: \_\_\_\_\_

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