2022-2023 Influenza Consent Form

Patient Information

Last Name:	Legal First Name:	M.I.:
Complete Address:		
Date of Birth (mm/dd/yyyy):	Date:	

Age Range of Patient : (check one) ☐ **6-35 months** ☐ **36 months – 64 years** ☐ **>/= 65 years**

Pre-Immunization Questionnaire:

	YES	NO
1. Is the person to be vaccinated sick today?	☐	☐
2. Does the person to be vaccinated have an allergy to a component of the vaccine?	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐
5. Is the person to be vaccinated allergic to eggs or egg products?	☐	☐
6. Is the person to be vaccinated allergic to latex?	☐	☐
7. If younger than 8 years of age, how many flu shots has the child received in their lifetime?	☐	☐

☐ 0 shots ☐ 1 shot ☐ 2 shots or more ☐ N/A

**It is recommended by the CDC that children younger than 8 years old who have received 1 or less flu shots, receive a second dose at least 28 days after the first dose to optimize response.*

I/My child has been offered the Influenza Vaccine to protect against seasonal influenza. I/My child have received a copy of the Vaccine Information Statement (VIS) and have read and/or had the information therein explained. I have been advised that the person to be vaccinated should remain in the area for 15 minutes after the vaccination for observation.

☐ **I have chosen to receive the vaccine, or I consent for my child to receive the vaccine. I attest that the above information is correct.**

Patient or Parent/Guardian Signature: _____ **Date:** _____

*For Internal Use Only

Date Administered: _____ **Client:** _____

Vaccine Manufacturer and Dose: ***(Check one)***

☐ Seqirus Flucelvax Quadrivalent 0.5 mL Prefilled Syringe
☐ Sanofi Fluzone Quadrivalent 0.5 mL Prefilled Syringe
☐ Seqirus Fluad Quad High Dose 0.5 mL Prefilled Syringe
☐ Sanofi Fluzone Quad High Dose 0.7 mL Prefilled Syringe
☐ Other: _____

Location of Clinic or Flu Clinic:

Address: _____
Apt./Ste.: _____
City: _____
State: _____ Zip: _____

Exp. Date: _____ **Lot Number:** _____

IM Injection Site: ☐ **RIGHT** Deltoid ☐ **LEFT** Deltoid ☐ **Other:** _____

VIS Given: ☐ Yes **Date of VIS:** 08/06/2021

Administered by: _____ **Date:** _____
Signature

Clinical Double Check *(recommended)*: _____ **Date:** _____
Signature

Clinician consult/review and signature is required to proceed with immunization if "Yes" was answered on any of the above questions.

Reviewed by: _____ **Date:** _____
Signature