INFLUENZA CONSENT FORM
2023-2024

USE BLACK OR BLUE INK ONLY PLEASE PRINT

Last Name:	First Name:	MI	Age:	D/O/B	□ Male □ Female
Street Address: (include Apt # if applicable)	City:	State:	Zip:		
Employer: ○ Employee ○ Spouse/Dependent ○ Retiree	Phone Number:	Parent/Guardian Name (if patient is a minor):			
	Email Address:				

SCREENING FOR FLU VACCINE ELIGIBILITY

1.	Any serious allergy to eggs, chickens, or chicken feathers?	Yes	No
2.	Ever had a serious reaction to previous dose of flu vaccine that required medical attention?	Yes	No
3.	Ever had Guillain-Barre Syndrome (temporary severe muscle weakness) after receiving flu vaccine?	Yes	No
4.	Any allergy to Thimerosal (Preservative found in contact lens solution) or Latex?	Yes	No
5.	Are you pregnant, or think you may be pregnant?	Yes	No
6.	Have you received any type of vaccine or antibiotic in the last 9 days?	Yes	No

DO NOT WRITE BELOW THIS LINE UNTIL YOU APPEAR FOR YOUR VACCINE

VACCINE ADMINISTRATION RECORD & WAIVER OF LIABILITY

I have read or have had explained to me the information provided about influenza and influenza vaccine. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to sign. I hereby release *One to One Health* from all liability associated with the administration and potential side effects of the vaccine.

This record is evidence and/or documentation that you have received the flu vaccine, and it will be filed with *One to One Health*. They will record what vaccine was given, when the vaccine was given, where the vaccine was given, the name of the company that made the vaccine, the vaccine's lot number, and the name and title of the person who gave the vaccine.

PATIENT SIGNATURE:_____ **DATE:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

FOR ADMINISTRATIVE USE ONLY

VIS Date: 8/6/2021

Vaccine	Route	Manufacturer	Lot No.	
Influenza Fluzone	*R-deltoid* *L-deltoid*	**Sanofi Pasteur**	**UT8109KA** **Exp: 06/2024**	**Printed Name of Vaccine Administrator**_____ **Signature of Vaccine Administrator**_____ **Date vaccination and VIS given:**____/___/_____ ☐ Patient tolerated vaccine well with no reaction or acute issues noted.