



INFLUENZA VACCINE CONSENT FORM AND ADMINISTRATION RECORD
PERSONAL INFORMATION (PLEASE PRINT)

NAME: _____ **BIRTHDATE:** ____/____/____ **AGE:** ____

ADDRESS: _____ **SEX: (Circle)** M F

CITY: _____ **STATE:** _____ **ZIP:** _____

I have read or have had explained to me the Vaccine Information Statement about influenza and the influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian).

SIGNATURE: _____ **DATE:** ____/____/____

PLEASE CIRCLE YOUR ANSWER TO THE FOLLOWING QUESTIONS:

- | | | |
|--|----|-----|
| 1. Have you received the flu vaccine before? | NO | YES |
| 2. Did you have any problems with previous flu shots? | NO | YES |
| 3. Do you have allergies to eggs or Thimerosal preservative? | NO | YES |
| 4. Are you ill today? | NO | YES |
| 5. Do you have a history of Guillain-Barre Syndrome? | NO | YES |
| 6. Do you suffer from asthma? | NO | YES |
| 7. Do you have any immune deficiency disease? | NO | YES |
| 8. If you are under age 9, have you received the flu vaccine before? | NO | YES |

OFFICE USE ONLY

LOT NUMBER: _____ **EXPIRATION DATE:** ____/____/____

Location of Immunization: **Arm:** L R **Leg:** L R