Influenza Vaccine Consent Form

Name: _____ Date: _____

Address: _____

Phone Number: _____ Date of Birth: _____ Email _____

You should not receive the Influenza vaccine if any of the following apply:

- You have ever had a serious allergic reaction to eggs, formaldehyde, gelatin, or to a previous dose of influenza vaccine.
- You have a history of Guillain-Barre Syndrome (GBS).
- You are ill.

Speak to your doctor if you are pregnant.
Influenza vaccine is indicated and recommended if your due date falls during the flu season (November to March).

Possible reaction:

Mild: Soreness or redness at the site of the shot, Fever, Body aches

Severe: Acute allergic reaction – high fever, confusion, difficulty breathing, hives, and rapid heartbeat would occur within a few minutes of the shot.

Guillain-Barre Syndrome – progressive muscle weakness and paralysis may occur a week after the vaccine. This occurs in 1-2 cases per million persons vaccinated.

QUESTIONS YOU MUST ANSWER	Check your Response
Are you ill today?	☐ Yes / ☐ No
Are you allergic to eggs?	☐ Yes / ☐ No
Have you ever had a severe reaction to a flu vaccine?	☐ Yes / ☐ No
Have you had Guillain-Barre Syndrome?	☐ Yes / ☐ No
Are you allergic to latex?	☐ Yes / ☐ No
Have you ever had a severe reaction to formaldehyde?	☐ Yes / ☐ No
Have you ever had a severe reaction to gelatin?	☐ Yes / ☐ No

Consent
I have read the current influenza vaccine information sheet. I have been provided an opportunity to ask questions about the disease and the treatment. I understand the risks and benefits of the vaccination. I understand that the vaccination I am to receive is single shot for adults and for children who have received a flu vaccine in the past.

I understand that it will not be fully effective for approximately two weeks. However, as with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I understand that one should not receive this vaccine if they have a severe allergy to eggs, have had a severe reaction to a previous influenza vaccine, or if they have had Guillain-Barre Syndrome. I hereby request the influenza vaccine for the 20___ - 20___ flu season, be given to myself or the person for whom I am authorized to give consent.

Patient Signature: _____ Date: _____

Manufacturer: _____ Exp: _____ Lot #: _____

Dose 0.5cc IM Location: ☐ R / ☐ L deltoid

Witnessed/Administered By: _____ Date: _____