Changing Health Care for Good.®

INFLUENZA VACCINE CONSENT 2024-2025 SEASON

PRINT PATIENT'S NAME:_________________________________ DOB:___________________ MRN:_________________

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Is the person receiving the vaccine allergic to chicken protein, eggs, or egg products?

(ex: hives, swelling of lips or acute respiratory distress or collapse) ☐ Yes ☐ No

2. Has the person receiving the vaccine previously had a serious reaction to the flu vaccine? ☐ Yes ☐ No

3. Is the person receiving the vaccine presently ill and/or have a fever? ☐ Yes ☐ No

4. Is the person receiving the vaccine now or think they may be pregnant? ☐ Yes ☐ No

If you answered YES to any of the above questions, you should not receive the vaccine without consulting a physician

Provider Notes if Applicable ____

WARNING

The Flu shot should not be given to people with a severe allergy (ex. anaphylaxis, hives, respiratory distress or collapse) to eggs or chicken protein.

POSSIBLE SIDE EFFECTS

Most common: Slight Swelling and tenderness at the injection site. This may last 24-48 hours. Fever or body aches lasting 1-2 days, especially in persons not previously exposed to the flu virus. NOTE: Because Influenza vaccine contains only noninfectious viruses, it cannot cause active Influenza, "the flu".

Unlike 1979 Swine Flu Vaccine, recent flu vaccines have not been clearly linked to the paralytic illness Guillain-Barre Syndrome. On very rare occasions, GBS may occur in the days or weeks after getting a vaccination.

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

Patient Signature_______________________________________ Date _____________________

Or Parent/Legal Guardian _______________________________ Date _____________________

FOR OFFICE USE ONLY ____

Vaccine Type/Brand: _________________ Dose: _____mL

[AFFIX LABEL HERE]

LOT _______________ Expiration____________

Administered by: _____________________________

NAME/CREDENTIAL (printed)

IM Injection Administered:
Location: Right Deltoid / Left Deltoid
Pediatric (birth-2yr) Right Vastus Lateralis / Left Vastus Lateralis

Reactions noted after vaccine given No____ Yes____ (If yes, notify the provider and document in EHR)

8/2024v