Billing ______
IRIS ________
HM ________

Influenza Vaccine Consent Form

I have been given a copy of the Influenza Vaccine Information Statement. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of Influenza Vaccine and request that this be given to me or to the person named below for whom I am authorized to make this request.

P L E A S E P R I N T C L E A R L Y

Full Name ____

Birthdate ______________________ **Age** __________ ☐ **Male** ☐ **Female**

Street Address ____

City / State / Zip ______________________ **Phone** ______________________

Family Physician ______________________

1. **Do you have a serious allergy to eggs?** **Yes No**
2. **Have you ever had an allergic reaction or other problem after a vaccination? (shortness of breath, hives, difficulty breathing, etc.)** **Yes No**
3. **Were you ever paralyzed by Guillain-Barre Syndrome within 6 weeks after receiving the influenza vaccine?** **Yes No**
4. **Do you feel well today?** **Yes No**

Signature X______________________ **Date** __________ **Time** __________
(Patient or Parent/Guardian)

For Office Use Only:

☐ **Private Insurance**
Company ______________________ **Policy #** ______________________
☐ **Medicare**
Company ______________________ **Policy #** ______________________
☐ **Medicaid**
Company ______________________ **Policy #** ______________________
☐ **No Insurance/Underinsured** **Employee of:**
☐ **VFC** ☐ **Self-Pay**

For Nurse Use Only:

☐ **Flulaval**-Private Lot# 495MK ☐ VFC Lot#: 2XK44; 332H7; 774N2
☐ **FluBlok** Lot# TFAA2413; TFAA2423; TFAA2435
☐ **Fluad** (65 yrs and older) Lot# 388472, 388464

IM Injection Site: (circle) RD LD

Date Vaccinated: ______________________ **Nurse Signature:** ______________________