Influenza Vaccine Consent Form

PATIENT INFORMATION				
Patient's **LEGAL** Last Name:	Patient's **LEGAL** First Name:	Phone Number:	Age:	Birthdate:
Street Address:	City:	County:	State:	Zip Code:

Legal Sex:
☐ Female ☐ Male

Are you Hispanic or Latino
☐ Yes ☐ No

Race: (Select one or more)
☐ AS-Asian/Pacific Islander/Other ☐ BL-Black or African American ☐ CH-Chinese
☐ CA-Caucasian (White)/Mexican/Puerto Rican ☐ FI-Filipino ☐ HA-Hawaiian
☐ IN-Native American/Alaska Native ☐ JA-Japanese
☐ NW-Other Non-White ☐ UN-Unknown

Insurance Company or Medicare:	ID#:	Group# (Insurance Only):	Primary Physician:

VACCINATION SCREENING QUESTIONNAIRE	
1. Do you have a serious allergy to eggs?	☐ Yes ☐ No
2. Do you have any other serious allergies? Please list:	☐ Yes ☐ No
3. Have you ever had a serious reaction to a previous dose of flu vaccine?	☐ Yes ☐ No
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐ Yes ☐ No
5. Have you received any other vaccine in the past 14 days? List:	☐ Yes ☐ No
6. Are you breastfeeding?	☐ Yes ☐ No ☐ N/A
7. Are you pregnant or have a chance of becoming pregnant within the next month?	☐ Yes ☐ No ☐ N/A

Please read and check each of the following statements then sign.

☐ I have been offered a copy of the most current Vaccine Information Sheet, whether accepted or not. I have read or had explained to me the information on the Information Sheet, including the possible adverse reactions, the components of the vaccine, the possible risks, and what to do after the vaccination.

☐ I ask that the vaccine be given to me or to the adult named above for whom I am authorized to make this request. I consent to the inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the above-named person.

☐ I do hereby solemnly swear that I have legal custody of the minor named above. I grant authorization and consent for Salina Family Healthcare Center to administer influenza vaccine to the above named minor and provide medical evaluation and treatment throughout the vaccine process, including administration of medications and calling EMS for transport to the nearest emergency department.

Signature of Patient or Parent/Guardian:_____ **Date:** _____

Staff use only:

VACCINE	*ROUTE*	*EXT*	*SITE*	*Date Administered*	*MANUFACTURER LOT #*	*EXP DATE*
Influenza	IM	**RT LT**	**Deltoid**			

Signature and Title of Vaccine Administrator _____ **Date Given** _____