

# CONSENT FORM FOR SEASONAL INFLUENZA VACCINE

I have read or have had explained to me the information about influenza and influenza vaccine. I have had an opportunity to discuss the benefits and risks of influenza vaccine with a healthcare provider of my choice before coming here today. 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 the vaccine be given to ME/ MY CHILD. (circle one)

**Please print:**

Title: \_\_\_\_\_ Name: \_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_  
(FIRST) (MIDDLE) (LAST)

Child's Birthday \_\_\_/\_\_\_/\_\_\_ & Age \_\_\_\_\_ (if applicable)

Parent or Guardian's Name: \_\_\_\_\_

**Vaccine is for (circle one):** Physician      Employee      Contractor      Volunteer  
Family Member (Adult)      Family Member (Child)      Other \_\_\_\_\_

**Company/Organization:** \_\_\_\_\_

Has the person receiving the vaccine ever had a severe allergic (hypersensitivity) reaction to eggs, chickens, or chicken feathers? \_\_\_Yes \_\_\_No

Does the person receiving the vaccine have a history of Guillain-Barré syndrome or a persistent neurological illness? \_\_\_Yes \_\_\_No

Is the person receiving the vaccine pregnant? \_\_\_Yes \_\_\_No (If yes, LAIV contraindicated, TIV recommended)

\_\_\_\_\_  
**Signature of person receiving vaccine OR Parent/Guardian**

\_\_\_\_\_  
**Date**

## DO NOT WRITE IN THIS SPACE—OFFICE USE ONLY

Lot number and Expiration Date: \_\_\_\_\_

CHECK ONE:

- \_\_\_ 0.5 mL IM Influenza Virus Vaccine given in left deltoid
- \_\_\_ 0.5 mL IM Influenza Virus Vaccine given in right deltoid
- \_\_\_ Children older than 9 years: 0.5 mL/dose (1 dose per season)

\_\_\_\_\_  
Nurse/ Provider's Signature

\_\_\_\_\_  
Date

