Your Medical Home

Flu Consent Form

Patient Name (please print)

DOB Gender SS#

Address City State Zip

Email Phone Number

Guardian Name Guardian Phone Number

Guardian Relationship Guardian DOB

Screening Questionnaire

Is the person receiving the vaccine at least 2 years old? YES NO

Has the person received the vaccine ever has a severe allergic (hypersensitivity) reaction to egg, chickens, or chicken feather? YES NO

Does the person receiving the vaccine have a history of Guillain-Barre syndrome or a persistent neurological illness YES NO

Has the person received a live vaccine within the past 30 days (i.e. MMR, Rota, Teq/Rotarix)?
* if yes, it is recommended to space live vaccines by >4 weeks for full efficacy. YES NO

Is the person receiving the vaccine pregnant? YES NO

Is the person receiving the vaccine allergic to Neomycin, Thimerosal, (Preservative found in contact lens solution), any vaccine ingredient, or latex? YES NO

For children 6 months - 8 years: Have they received 2 or more doses of influenza vaccine since 2015? YES NO

For children and adolescents age 2-17 years: Is the child taking long-term aspirin or aspirin-containing therapy? YES NO

Signature of person receiving the vaccine OR parent/ guardian: **Date:**

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INSURANCE INFORMATION:

Are you the primary insured: ☐ Yes ☐ No Relation To Primary:

Insurance Subscriber: Subscriber DOB:

Subscriber SSI#: Employer:

Insurance: Type: HMO PPO POS HSA Medicare Other:

Copay/Co-Insurance: Deductible: Group #:

Signature of person receiving the vaccine OR parent/ guardian: **Date:**

DO NOT WRITE IN THIS SPACE- OFFICE USE ONLY:

VIS Edition Provider: _____ Lot Number: _____ Expiration Date: _____

_____ 0.5 mL IM influenza virus vaccine given in _____ left _____ right deltoid - TIV or QIV
_____ 0.5 mL IM influenza HIGH DOSE virus vaccine given in _____ left _____ right deltoid - (65 + TTV - SR
_____ 0.5 mL intradermal virus vaccine site _____ - TIV
_____ 0.5 mL FluBlok influenza virus vaccine given in _____ left _____ right deltoid
_____ Children 3-8 years: 0.5mL/ dose given in _____ left _____ right deltoid (1 or 2 doses per season)
_____ Children older than 9 years: 0.5mL/ dose given in _____ left _____ right deltoid (1 or 2 doses per season)

Nurse/ Provider's Signature **Date:**