Your Medical Home

Flu Vaccine 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

Question		
Is the person getting vaccinated sick today?	YES	NO
Is the person receiving the vaccine at least 2 years old?	YES	NO
Has the person receiving the vaccine ever had 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?	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:**

---

*If filling on personal insurance please fill out the top of the back page.

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:**