2022-23 Flu Vaccination Consent Form

PATIENT NAME (LAST, FIRST, MI):	GRADE: TEACHER:
DOB: AGE:	GENDER: ___MALE ___ FEMALE
MAILING ADDRESS:	PHONE:
CITY	***FOR PATIENTS UNDER 18 YEARS OLD:***
STATE, ZIP	PARENT/GUARDIAN(s) NAME (LAST, FIRST, MI)

Flu Vaccine Preference: Flu Shot_____ Nasal Mist_____ (Note: must be between 2 and 49 without respiratory problems or pregnancy to receive nasal mist- *please read Vaccine Information Statement*)

PLEASE MARK THE APPROPRIATE BOX	**Yes**	**No**
1) Are you sick today?		
2) Have you ever had a flu shot or flu mist?	____	____
If YES, When? _____		
3) Are you allergic to eggs, egg products or a component of the flu vaccine?	____	____
4) Have you ever had a serious reaction to the flu shot or flu mist?	____	____
5) Do you or anyone in your household have a weakened immune system?	____	____
6) Do you have a history of Guillain-Barre Syndrome?	____	____

For those who are considering the FLU NASAL MIST please continue on

7) Do you have a long term heart, kidney, liver or nervous system problems?	____	____
8) Are you a child or teen receiving aspirin or aspirin-containing therapy?	____	____
9) Have you received any other vaccinations in the past four (4) weeks ?	____	____
10) Are you pregnant or plan to become pregnant within the next month?	____	____
11) Are you receiving antiviral medications within 48 hours?	____	____
12) Do you have asthma, wheezing episodes or other breathing problems?	____	____

CONSENT FOR VACCINE ADMINISTRATION:

Patient/ Guardian Signature_____ Date_____

For Nurse Use Only

DATE	ITEM CODE	LOT #	VACCINE ADMIN SITE	VACCINATOR INITIALS
	FLU-Prefilled Syringe (0.5 ml) FLU-Prefilled Syringe (0.25ml) FLU MIST		RA LA RT LT NASAL	