INFLUENZA CONSENT FORM
2023-2024

Last Name:	First Name:	MI	Age:	D/O/B	Male Female

Street Address: (include Apt # if applicable)	Race: American Indian Asian White Black/African American Native Hawiian Other	Ethnicity: Hispanic/Latino Not Hispanic/Latino

Employer Name: Employee Spouse/Dependent Retiree	Phone Number: Email Address:

SCREENING FOR FLU VACCINE ELIGIBILITY	YES	NO
1. Any serious allergy to eggs, chickens, or chicken feathers?		
2. Ever had a serious reaction to previous dose of flu vaccine that required medical attention?		
3. Ever had Guillain-Barre Syndrome (temporary severe muscle weakness) after receiving flu vaccine?		
4. Any allergy to Thimerosal (Preservative found in contact lens solution) or Latex?		
5. Are you pregnant, or think you may be pregnant?		
6. Have you received any type of vaccine or antibiotic in the last 9 days?		

DO NOT WRITE BELOW THIS LINE UNTIL YOU APPEAR FOR YOUR VACCINE

VACCINE ADMINISTRATION RECORD & WAIVER OF LIABILITY

I have read or have had explained to me the information provided about influenza and influenza vaccine. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to sign. I hereby release *One to One Health* from all liability associated with the administration and potential side effects of the vaccine.

This record is evidence and/or documentation that you have received the flu vaccine, and it will be filed with *One to One Health*. They will record what vaccine was given, when the vaccine was given, where the vaccine was given, the name of the company that made the vaccine, the vaccine's lot number, and the name and title of the person who gave the vaccine.

PATIENT SIGNATURE:______________________________ **DATE:** ______________

PARENT/GUARDIAN Name: ______________________________ **DATE:** ______________

PARENT/GUARDIAN SIGNATURE: ______________________________ **DATE:** ______________

FOR ADMINISTRATIVE USE ONLY — **VIS Date: 8/6/2021**

Vaccine	Route	Manufacturer	Lot No.	
Influenza	*R-deltoid* *L-deltoid*			**Printed Name of Vaccine Administrator**______________ **Signature of Vaccine Administrator**______________ **Date vaccination and VIS given:**____/____/________ ☐ Patient tolerated vaccine well with no reaction or acute issues noted.