



Influenza Vaccine Consent Form

Name: _____

Date of Birth: / /

You should not receive the Influenza vaccine if any of the following apply:

- ❖ You have ever had a serious allergic reaction to eggs, formaldehyde, gelatin, or to a previous dose of influenza vaccine.
- ❖ You have a history of Guillain-Barre Syndrome (GBS).
- ❖ You are ill.

Speak to your doctor if you are pregnant.

QUESTIONS YOU MUST ANSWER Circle your Response

Are you ill today? Yes / No

Are you allergic to eggs? Yes / No

Have you ever had a severe reaction to a flu vaccine? Yes / No

Have you had Guillain-Barre Syndrome? Yes / No

Are you allergic to latex? Yes / No

Have you ever had a severe reaction to formaldehyde? Yes / No

Have you ever had a severe reaction to gelatin? Yes / No

CONSENT:

I have been provided an opportunity to ask questions about the influenza vaccine and I understand the risks and benefits of the vaccination. I hereby request the influenza vaccine be given to myself or the person for whom I am authorized to give consent.

Patient Signature: _____ **Date:** / /

Office Use:

Manufacturer: Exp: Lot #: _____

Administered By: _____ Date: / /