Informed Consent for Seasonal Influenza Vaccine

Patient Name _____ (please print)

Date of Birth _____

Please answer the questions below:

Yes	No	
		Do you have a serious allergy to eggs?
		Have you ever had an allergic reaction or other problem after a vaccination? (Shortness of breath, hives, difficulty breathing, etc)
		Were you ever paralyzed by Guillain-Barre Syndrome within 6 weeks after receiving the influenza vaccine?
		Do you feel well today?

If you have had recent chemotherapy, radiation therapy or steroids (except inhaled), these conditions may decrease the effectiveness of the vaccine. However, influenza vaccination is still encouraged.

Influenza vaccination is recommended for any woman who will be pregnant or breastfeeding during the influenza season. Vaccination may be done during any trimester of pregnancy.

I have read the information above and my signature below indicates my informed consent, or my informed consent for my child to receive the seasonal influenza vaccine.

_____ _____ _____

Signature of Patient or Legal Guardian | Date | Time

_____

Witness and name of person who explained consent

Influenza Vaccine

(Inactivated Influenza Vaccine)

Vaccine Lot #_____

Expiration Date _____

Floyd Valley Clinics

Consent 2015.doc.consents.administration
Approved by Risk Management 09/16/19
Revised 9/8/10, 1/7/16, 9/19/18, 09/16/19