

ADULT INFLUENZA VACCINE CONSENT

PATIENT NAME: _____ **DOB:** _____
ADDRESS: _____ **PHONE:** _____

The following questions will help us determine whether you can receive the Influenza vaccine today. If you answer "Yes" to any questions it does not necessarily mean that you cannot receive the vaccine. It just means that we may need to ask additional questions.

	Yes	No	Don't Know
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had a fever within the last 48 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had a reaction to the Influenza vaccine or any other vaccine in the past? If "Yes" which one?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you allergic to eggs or egg products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you allergic to any medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Which ones?			
6. Are pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have a prior history of Gullian-Barre Syndrome (GBS)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you experienced any wheezing in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Form completed by:	Date:		
Form reviewed by:	Date:		

If you choose to be immunized with the Influenza Virus Vaccine, please read the following information and sign below.

- I agree to receive the Influenza Virus Vaccine.
- The CDC Vaccine Information Statement has been provided to me with all the necessary information so I can make an informed decision.
- I understand the risks of the Influenza Virus Vaccine.
- I understand that the Influenza Virus Vaccine is highly recommended for anyone with the following health conditions: heart disease, lung disease, asthma, kidney disease, metabolic diseases (such as diabetes) and persons over the age of 6 months.
- I have been provided the opportunity to ask questions about the disease, the vaccine, and how the vaccine is to be administered.
- I know that I will have the vaccine injected into my body to help prevent the influenza virus.
- I am a competent adult and am freely providing my consent for this vaccine to be administered.
- Payment:** I understand that I am responsible for payment in full for this service and that payment is due at the time of service.

By signing below you authorize Austin Children's Clinic, PA to administer the Influenza Virus Vaccine to the above named child. You also agree to pay any unpaid charges for this vaccine.

Patient Signature: _____ Date: _____

STAFF USE ONLY		Temperature	
Family Account #		Manufacturer & Lot	
VIS Date		Administration Site	