ADULT INFLUENZA VACCINE CONSENT - AGES 18 THROUGH 64

(We are unable to adminster influenza vaccine to anyone 65 years and older)

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?	☐	☐	☐
2. Have you had a fever within the last 48 hours?	☐	☐	☐
3. Have you had a reaction to the Influenza vaccine or any other vaccine in the past? If "Yes" which one?	☐	☐	☐
4. Are you allergic to eggs or egg products?	☐	☐	☐
5. Are you allergic to any medications?	☐	☐	☐
Which ones?			
6. Are pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
7. Do you have a prior history of Gullian-Barre Syndrome (GBS)?	☐	☐	☐
8. Are you immunocompromised or have a weakend immune system?	☐	☐	☐
9. Have you experienced any wheezing in the last 12 months?	☐	☐	☐
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.

1. I agree to receive the Influenza Virus Vaccine.
2. The CDC Vaccine Information Statement has been provided to me with all the necessary information so I can make an informed decision.
3. I understand the risks of the Influenza Virus Vaccine.
4. 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.
5. I have been provided the opportunity to ask questions about the disease, the vaccine, and how the vaccine is to be administered.
6. I know that I will have the vaccine injected into my body to help prevent the influenza virus.
7. I am a competent adult and am freely providing my consent for this vaccine to be administered.
8. **Payment:** I understand that the flu vaccine will be billed to my health insurance company (listed below) and that I am responsible for payment for any unpaid amout, including copay, coinsurance, deductibles and any amount that is not paid by my insurance.

Insurance Company:	ID:

By signing below you authorize Austin Children's Clinic, PA to administer the Influenza Virus Vaccine to you. 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	