Clinic Location: _____

Time Vaccinated: _____

2020-2021 SEASONAL INFLUENZA VACCINE

RECORD AND CONSENT FORM

SECTION 1: PATIENT INFORMATION

Last Name	First Name	M.I.	Date of Birth Month__Day___Year _____	Age
Sex assigned at birth ☐Male ☐Female ☐Choose not to disclose	Race: ☐ White ☐ Black or African American ☐ Asian ☐ Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other			Ethnicity ☐ Hispanic ☐ Non-Hispanic

Mailing Address	City	State	Zip Code

Home Phone ( ) -	Work Phone ( ) -	Cell Phone ( ) -	Emergency Contact Name and Phone ( ) -

SECTION 2: SCREENING QUESTIONS

Please answer the following questions. If you answer "yes" to any of the questions, please contact your medical provider to discuss other ways to receive the vaccine.	**YES**	**NO**
1. Are you sick today?		
2. Do you have a serious allergy to eggs or any component of the influenza vaccine?	◯	◯
3. Have you ever had a severe life-threatening reaction after a dose of the influenza vaccine or been told to not get the influenza vaccine by a healthcare provider?	◯	◯
4. Have you ever had Guillain-Barré Syndrome (an autoimmune neurological condition that results in sudden muscle weakness)?	◯	◯

SECTION 3: CONSENT FOR VACCINATION

I have been provided information about the influenza vaccine and been given the Vaccine Information Statement to review today. I have had any questions satisfactorily answered. I understand the risks and the benefits of receiving the influenza vaccine, and I agree to be given the influenza vaccine today. All information provided on this form will be held confidential and will be maintained in accordance with the confidentiality provisions of state and federal law.
I certify that this form has been fully explained to me, that I have read it, or have had it read to me, and that I understand its contents.
By signing below, I am indicating my consent to be vaccinated against influenza.

Yes, I do want to receive the influenza vaccine.

Signature of Patient _____ Date _____

SECTION 4: ADMINISTRATIVE (INTERNAL) USE ONLY. Vaccine administrator must complete all sections.

BEFORE vaccinating check that you have completed the following (check to confirm done):

☐ I have reviewed this entire form. If "yes" to any of the screening questions, do NOT give the vaccine.

Publication date on Vaccine Information Statement (VIS): 8/15/19

☐Patient Not Vaccinated
Reason:_____

Provider Name & Address:	**Name and Title of Vaccine Administrator:**
	Signature of Vaccine Administrator:

Vaccine	**Manufacturer**	**Lot Number**	**Route**	**Admin Date**
			☐ IM L Deltoid ☐ IM R Deltoid ☐ Other _____	/ /

After vaccination this form was reviewed by: _____