PRIORITY PRIVATE CARE

FLU VACCINATION CONSENT

Patient Name: _____ **Date of Birth:** _____

Age: _____ **Sex:** _____ **Allergies:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

I, the undersigned, have read or had explained to me the vaccine information sheer (VIS). I understand the risks and benefits associated with the influenza vaccine and have had any questions satisfactorily answered. I voluntarily request that the vaccine to be given to me or for the aforementioned person for whom I am authorized to make this request.

_____ _____

Signature **Date**

SCREENING QUESTIONS	Yes	No	Unk
Are you currently ill or do you have a fever?			
Have you received the vaccine before?			
Have you had a reaction to the vaccine?			
Have you been sick in the last 2 weeks?			
Are you allergic to egg or dairy products?			
Are you allergic to thimerosal?			
Are you pregnant?			
Are you a Health Care worker?			
Have you ever had Guillain-Barre syndrome?			
Do you have a blood-clotting disorder?			
Are you taking blood-thinning medication?			

FOR OFFICE USE ONLY

Date Given: _____ Site: _____ Route: _____

Exp. Date: _____ Lot #: _____ Manufacturer: _____

Administered By: _____