Influenza Consent Form

Name_____ **Date of Birth**____/____/____ M___F___ Age ____
(Please print)

Address_____City/State_____Zip_____

Telephone_____ Physician_____

Email: _____@ _____

Insurance Co.	ID #	Group #	Prim Ins.	SecondIns.

Subscriber's name: **Subscriber's Date of Birth / / _**

PLEASE COMPLETE AND SIGN

Is this your first flu vaccination ever? . . . . . ☐ Yes ☐ No
Have you ever had a serious reaction to a flu shot? . . . . . ☐ Yes ☐ No
Are you allergic to eggs or other components of the vaccine?. . . . ☐ Yes ☐ No
Did you ever become ill with Guillain Barre Syndrome after a flu vaccine? . . ☐ Yes ☐ No
Are you sick with a fever today? . . . . . ☐ Yes ☐ No
Are you pregnant?..... ☐ Yes ☐ No
Have you received any other vaccines in the past 4 weeks?..... ☐ Yes ☐ No

Do you take Aspirin or anticoagulant (blood-thinner) medications daily?..... ☐ Yes ☐ No

I have read or had explained to me, the information sheet about influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described.
I request that the flu vaccination be given to me.
I authorize the release of any medical or other information necessary to process an insurance claim or for other public health reasons. I request all payments made on my behalf to be paid directly to the Uncas Health District.
I understand that UHD may bill me for any co-payment or deductible that is my responsibility.

X

Vaccine Recipient's Signature/ or parent/guardian **Date**

For Health Department use:

Manufacturer and Lot number: Manufacturer _____ lot#_____ _____ exp. _____

Flu Vaccine administered: IM ☐ **Left arm** ☐ **Right arm** **VIS Provided**: ____ **Published date:** 8/6/2021

Nurse Signature_____**Date**_____
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