



Affix Patient Label Here:

SEASONAL INFLUENZA VACCINE CONSENT

NAME: _____

Date Of Birth: _____ **Physician:** _____

Address: _____

Phone: _____ **Email** _____

*Are you allergic to eggs? YES _____ NO _____

* Have you ever had a serious allergic reaction to the influenza vaccine or any other vaccine? YES _____ NO _____

*Were you ever paralyzed by Guillain-Barre Syndrome? YES _____ NO _____

*Currently are you moderately or severely ill?
(People with a mild illness can get the vaccine) YES _____ NO _____

*I have been given the 8/15/19 Vaccine Information Sheet (VIS)? YES _____ NO _____

X _____ DATE: _____

Signature of person to receive vaccine or person authorized to make the request, parent or guardian.

Vaccine Name:

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

Site of Injection: _____ Date Vaccine Administered: _____

Signature/Title of Vaccine Administrator _____