

Influenza Vaccine Consent Form

1 PATIENT IDENTIFICATION

Patient Name:	Date of Birth:
Address:	Gender:
City, State, Zip:	Phone #:

2 SCREENING QUESTIONS

Have you received the flu vaccine before?
Severe reaction to the flu vaccine in the past?
Serious allergy to chicken eggs?
History of Guillian-Barre Syndrome (GBS)?

3 INSURANCE INFORMATION – PATIENT OR FACILITY TO PROVIDE A COPY TO PHARMACY

I receive health insurance from this facility Name of facility: _____

4 CONSENT & RELEASE

By signing, I have received and agreed to the following:

- Received and read the vaccine information sheet regarding benefits/risks of receiving the Influenza vaccine
- Had the opportunity to have questions answered regarding the vaccine;
- Consented to be immunized;

I hereby release Wellness Pharmacy Services, its employees, agents, representatives and assigns, including but not limited to the property owner upon which the event takes place, and its respective parent, subsidiary and affiliated companies, from any and all liability that may be associated with my receipt of the influenza vaccine.

Signature: _____ Today's Date: _____

Parent/Guardian Signature (if under 18): _____ Today's Date: _____

VACCINE ADMINISTRATION INFORMATION FOR IMMUNIZER/PHARMACIST/NURSE ONLY

Administration Date:	Vaccine Type: <input type="checkbox"/> Afluria 23/24 QIV <input type="checkbox"/> Fluzone HD 23/24 (65+)	Lot#:
Route: <input type="checkbox"/> Arm <input type="checkbox"/> Leg Site: <input type="checkbox"/> Left <input type="checkbox"/> Right	Vaccine Expiration:	Patient Temperature:
Immunizer Name & Title:		Immunizer Signature: