



# Influenza Vaccine Consent Form

## Section 1: Information About the Person Who Will Receive Influenza Vaccine (please print)

<b>FIRST NAME</b>	<b>MIDDLE INITIAL</b>	<b>LAST NAME</b>	<b>MAIDEN NAME OF PATIENT'S MOTHER</b>
<b>DATE OF BIRTH (mm/dd/yyyy)</b>	<b>AGE</b>	<b>GENDER (Please circle)</b> Male      Female	<b>SOCIAL SECURITY NUMBER</b>
<b>ETHNICITY (Please Check)</b> Hispanic/Latino <input type="checkbox"/> Yes / <input type="checkbox"/> No	<b>RACE (Please Check)</b> <input type="checkbox"/> African American/Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latino American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other		
<b>HOME ADDRESS</b>			
<b>CITY</b>		<b>STATE</b>	<b>ZIP CODE</b>
<b>INSURANCE INFORMATION:</b>		<b>Insurance Information:</b>	
<input type="checkbox"/> Aetna <input type="checkbox"/> Peachcare for Kids <input type="checkbox"/> No Insurance <input type="checkbox"/> Ambetter <input type="checkbox"/> United Healthcare <input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> UMR <input type="checkbox"/> BCBS/ANTHEM <input type="checkbox"/> TRICARE Standard <u>ONLY</u> <input type="checkbox"/> Cigna <input type="checkbox"/> Other _____ <input type="checkbox"/> Medicaid/Medicare/Amerigroup/Peachstate/Wellcare/CareSource		<b>Name of Policy Holder/Name on ID Card:</b> _____  <b>Member ID#</b> _____ <b>Group#</b> _____ <i>Please attach a copy of the insurance card to this form.</i>	

## Section 2: Medical Information: The following questions will help us to determine if this you can receive the influenza vaccine.

*\*Please circle Yes or No for every question.*

1. Have you received any vaccines in the last four weeks? If yes, please list:	Yes	No
2. When were you last vaccinated for flu? Date or Year:		
3. Have you ever had a serious allergic reaction to eggs?	Yes	No
4. Have you ever had a serious reaction to any influenza (flu) vaccine?	Yes	No
5. Do you use an inhaler or receive breathing treatments for asthma or a wheezing condition?	Yes	No
6. Are you on long term aspirin or aspirin-containing therapy? (For example: do you take aspirin everyday?)	Yes	No
7. Do you have any significant or chronic (long term) health conditions? (For example: diabetes, sickle cell disease, heart condition, lung condition, seizure disorder, cerebral palsy, muscle or nerve disorder, juvenile arthritis)	Yes	No
8. Do you have a weak immune system? (For example, from HIV, cancer, or from taking medications such as steroids or those used to treat cancer)?	Yes	No
9. Have you ever had Guillain-Barre Syndrome (GBS)?	Yes	No
10. Females only: Are you pregnant?	Yes	No
11. Have you taken any flu antiviral medications in the last 48 hours? (For example, Tamiflu, Relenza, etc.)	Yes	No

## Section 3: Consent to vaccinate:

<b>CONSENT TO RECEIVE INFLUENZA VACCINE</b>	
<p><i>By signing below, I acknowledge that the medical information provided above is correct. I have been given a copy of the VACCINE INFORMATION STATEMENT for INFLUENZA VACCINE. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine.</i></p>	
<b>Signature of Patient/Parent or Legal Guardian:</b> _____ <b>Date:</b> _____	
<b>FOR CLINIC USE ONLY</b>	
<b>Inactivated Influenza Vaccine 2022-23</b> <b>Administration Route:</b> <input type="checkbox"/> IM / <u>LEFT</u> Deltoid <input type="checkbox"/> IM / <u>RIGHT</u> Deltoid  <b>Mfg:</b> _____ <b>Lot #</b> _____ <b>Exp Date:</b> _____	<b>Intranasal Influenza Vaccine 2022-23</b> <b>Administration Route:</b> <input type="checkbox"/> <u>Intranasal</u>  <b>Mfg:</b> _____ <b>Lot #</b> _____ <b>Exp Date:</b> _____
<b>Nurse Signature:</b> _____ <b>Date:</b> _____ <b>Entry Clerk Initial:</b> _____ <b>Date:</b> _____	

**PUBLIC**
**\$PRIVATE\$**

**VHN Code:** \_\_\_\_\_