# Adult Flu Vaccine Consent Form

Georgia Department of Public Health
Coastal Health District

**VHN Code:**

Scan for flu shot info sheet -->

Scan for flu intranasal vaccine info sheet -->

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

| FIRST NAME | MIDDLE | LAST NAME | MAIDEN NAME OF PATIENT'S MOTHER |
|---|---|---|---|
| | | | |
| **DATE OF BIRTH (mm/dd/yyyy)** | **AGE** | **GENDER (*Please circle*)** Male Female | **SOCIAL SECURITY NUMBER** |
| | | | |

**ETHNICITY *(Please Check)***

Hispanic/Latino ☐ Yes ☐ No

**RACE *(Please Check)***

☐ African American/Black ☐ White ☐ Hispanic or Latino American ☐ American Indian
☐ Asian ☐ Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other

**HOME ADDRESS** **PHONE NUMBER**

**CITY** **STATE** **ZIP CODE**

**INSURANCE INFORMATION**

☐ No Insurance ☐ Insurance

***Please attach a copy of the insurance card to this form.***

**Name of Policy Holder/Name on ID Card:** _____

**Member ID#** _____ **Group#** _____

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

***Please circle Yes, No, or I Don't Know (IDK) for every question.***

| | | | |
|---|---|---|---|
| 1. Are you sick today? | Yes | No | IDK |
| 2. Do you have allergies to medications, food, a vaccine component, or latex? | Yes | No | IDK |
| 3. Have you ever had a serious reaction after receiving a vaccine? | Yes | No | IDK |
| 4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy? | Yes | No | IDK |
| 5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems? | Yes | No | IDK |
| 6. Do you have a parent, brother, or sister with an immune system problem? | Yes | No | IDK |
| 7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? | Yes | No | IDK |
| 8. Have you had a seizure or a brain or other nervous system problem? | Yes | No | IDK |
| 9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19? | Yes | No | IDK |
| 10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug? | Yes | No | IDK |
| 11. Are you pregnant? | Yes | No | IDK |
| 12. Have you received any vaccinations in the past 4 weeks? | Yes | No | IDK |
| 13. Have you ever felt dizzy or faint before, during, or after a shot? | Yes | No | IDK |

## Section 3: Consent to vaccinate:

**CONSENT TO RECEIVE VACCINE**

***By signing below,*** I acknowledge that the medical information provided above is correct. I have been given a copy of and/or scanned to view the VACCINE INFORMATION STATEMENT. I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the vaccine.

**Signature of Patient:** _____ **Date:** _____

**FOR CLINIC USE ONLY**

### Record of Immunization

| VACCINE | MFR. | LOT # | EXP. | DOSAGE | ROUTE | SITE | VIS | NURSE |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**Nurse Signature:** _____ **Date:** _____ **Entry Clerk Initial:** _____ **Date:** _____

**Date of Vaccination:** _____

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