HEALTH CARE PROVIDER INFLUENZA VACCINE CONSENT FORM 2024-2025

clinic stamp

Last name: _____ **First name:** _____ **Phone number:** _____

Street Address: _____ **City**: _____ **Postal Code:** _____

Gender: Male◯ Female◯ Other◯ **Date of Birth:** Year _____ Month _____ Day _____ Age: _____

*For children 6 months of age to less than 9 years of age who have NOT been previously vaccinated with **seasonal** influenza vaccine, is this the first or second dose of seasonal influenza vaccine this year?

First ◯ Second ◯ If second, please indicate the date of the first dose: _____/_____/____ (year, month, day)

Screening Questions:

Are you feeling ill today?	Yes ◯ No◯
Have you ever had an allergic reaction to a vaccine?	Yes ◯ No◯
Are you allergic to: • **Thimerosal (multi-dose vials only)** • **Kanamycin and/or Neomycin (Fluad only)**	Yes ◯ No◯
Do you have a bleeding disorder?	Yes ◯ No◯
Are you on medication(s) that affect blood clotting?	Yes ◯ No◯
Have you ever been diagnosed with: • **Guillian-Barre Syndrome (GBS)** • **Oculo-respiratory Syndrome (ORS)**	Yes ◯ No◯
Please explain any "Yes" answers provided above:	

Consent:

I have read (or it has been read to me) and I understand the "Influenza Vaccine Fact Sheet". I have had the opportunity to ask questions and have had them answered to my satisfaction. I consent to receiving the seasonal influenza vaccine. In addition, I am aware that the personal health information collected on this form may be shared with another healthcare provider if it is required for my care.

If signing for someone other than yourself, indicate your relationship to that other person: _____

If signing for someone other than myself, I confirm that I am the parent / legal guardian or substitute decision maker.

Signature: _____ **Print:** _____

Date of signature: _____

For Clinic Use Only: ◯ 1 ½ " needle used

Vaccine	Dose (mL)	Lot #	Exp.	Site (IM)	Time	Date	Provider Signature

Comments: _____