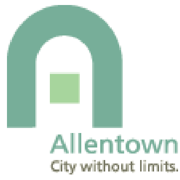

INFLUENZA VACCINE CONSENT

Information about the person receiving the vaccine (Please Print)

Last Name	First Name	Middle Name

Mailing Address	Apt/Suite

City	State	Zip	County

Date of Birth	Phone Number

GENDER

☐ Male ☐ Female

SPOKEN LANGUAGE

☐ **English** ☐ **Spanish**
☐ Arabic ☐ Russian
☐ German ☐ French
☐ **Other:** ____________________

DO YOU HAVE DIABETES?

☐ YES ☐ NO

RACE (Check all that apply)

☐ Aleut ☐ Japanese
☐ Arabian ☐ Korean
☐ Asian Indian ☐ Laotian
☐ **Black** ☐ Other Asian
☐ Cambodian ☐ Refused
☐ Chinese ☐ Samoan
☐ Eskimo ☐ Thailander
☐ Filipino ☐ Unknown
☐ Guamian ☐ Vietnamese
☐ Hawaiian ☐ **White**
☐ Indian
☐ **Other:** ____________________

HISPANIC ORIGIN

☐ Cuban ☐ Mexican
☐ **Non-Hispanic** ☐ Puerto Rican
☐ Refused ☐ South/Central America
☐ Unknown ☐ Unknown Hispanic
☐ **Other:** ____________________

HEALTH PLAN

☐ No Insurance ☐ Medicaid
☐ Private Insurance
☐ Medicare ☐ Unknown
☐ **Other:** ____________________

Question		
Have you ever had a reaction to a previous dose of influenza vaccine?	☐ Yes	☐ No
Do you have a serious allergic reaction to eggs?	☐ Yes	☐ No
Have you experienced an episode of Gullian-Barre Syndrome within the past six months?	☐ Yes	☐ No

I have read or have had explained to me the information in “Vaccine Information Statement: Influenza Vaccine: WHAT YOU NEED TO KNOW 8/7/2015.” I have had a chance to ask questions. Any questions were addressed to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

X ____ ____________________

Signature Date

For Clinic Use Only

Vaccination Date: ______________ Dose Volume: 0.25mL 0.5mL

Injection Site: LD RD Route: IM

Manufacturer: ____________________ Lot Number: ____________________

Signature of Vaccine Administrator

Signature Date

Revised 090216