

Annual Influenza Vaccine Consent Form-FLU SHOT

Section 1: Information about Patient to Receive Vaccine (please print)

Patient's name: _____ **Birth date:** ____/____/____

Gender: Male Female Other

Race: Asian Black or African America Hispanic or Latino White Other

Legal guardian's name (for patients under the 16): _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone: (____) _____

Section 2: Screening for Vaccine Eligibility

Was your child vaccinated with the seasonal influenza vaccine after July 1, 2019? YES NO

The following questions will help us to know if your child can get the seasonal influenza vaccine. If you answer "NO" to all four of the following questions, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, your child may be able to get the seasonal influenza vaccine, but we will contact you to discuss your options. Please mark YES or NO for each question.

	YES	NO
1. Does the patient have a serious allergy to eggs?		
2. Does the patient have any other serious allergies? Please list: _____		
3. Has the patient ever had a serious reaction to a previous dose of flu vaccine?		
4. Has the patient ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

Section 3: Consent

I have read or have had explained the Vaccine Information Sheet provided about the vaccine myself or my child is to receive. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of vaccination and ask that the vaccine be given to the person named above for whom I am authorized to make this request. I have read and answered the questions on this form carefully and accurately. I understand that incorrect information could cause serious risks to myself or my child. I understand immunization information about my child will be reported to the SC immunization Registry for public health purposes. I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration. I hereby release and agree to hold Prisma Health, its Board, physicians, employees, volunteers, medical staff and agents harmless, in and from any and all liability, claims, or damages arising or claimed as arising, out of or in relation to this Consent.

X: _____ Date: _____

How did you hear about this clinic? Radio _____ School _____ Other _____

Did you receive a flu shot last year? Yes _____ No _____

Do not write below line- for internal use only

Vaccine Name: _____ Lot # _____ Exp _____ Amount _____
Site _____ Date given _____ Administered by _____
Documented in State Registry _____ Date documented _____