2017-2018 Inactivated Influenza Vaccine Consent Form

Name of Individual to be Immunized _____

Address _____ **Phone** _____

Date of Birth _____/_____/_____ **Age** _____ **Male** ☐ **Female** ☐

PLEASE ANSWER THE FOLLOWING QUESTIONS

Have you had a flu shot before?	YES ☐	NO ☐	UNKNOWN ☐
Have you had an allergic reaction to a flu shot before?	YES ☐	NO ☐	UNKNOWN ☐
Are you allergic to chicken, eggs, or egg products?	YES ☐	NO ☐	UNKNOWN ☐
Are you sick or do you have a fever today?	YES ☐	NO ☐	UNKNOWN ☐
Are you currently taking an antibiotic for infection?	YES ☐	NO ☐	UNKNOWN ☐
Are you pregnant or think you may be?	YES ☐	NO ☐	UNKNOWN ☐
Do you have a blood clotting disorder or take blood thinning medication?	YES ☐	NO ☐	UNKNOWN ☐

Ackowledgement:

I am at least 18 years of age. I have read or have had explained to me the "Influenza Vaccine: What You Need to Know" vaccine information sheet. I have been given the opportunity to ask questions of a Flagler County Free Clinic health care professional concerning the influenza vaccine, including the risks and benefits of receiving the influenza vaccine. All of my questions concerning the vaccine have been answered to my satisfaction. I understand the risks and benefits of the influenza vaccine and request that it be administered to me.

Release of Liability:

I have read and understand the acknowledgements set forth above, and I hereby release the Flagler County Free Clinic and their affiliated entities, and all of their agents, employees, and representatives, from any and all liability which may arise from the vaccination and/ or from the information provided to me concerning such vaccinations.

Consent to Vaccination:

I have read and I understand the information set forth in this for. Based on that understanding, I hereby CONSENT to an inactivated influenza vaccination provided to me by the Flagler County Free Clinic.

_____ _____/_____/_____ _____

Signature of Recipient of Vaccination | Date | Printed Name of Recipient of Vaccination

If signed by someone other than recipient, please indicate name and relationship_____

_____ _____/_____/_____ _____

Signature of Witness | Date | Printed Name of Witness

For Office Use Only

Flu vaccine lot #: _____ Manufacturer: _____

EXP: _____ Date: _____/_____/_____

Site of injection: Right Deltoid ☐ Left Deltoid ☐