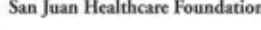

Consent to Administer Influenza Vaccine

Precautionary checklist:

1. Allergic to eggs or egg products? ☐ Yes ☐ No
2. Current respiratory illness or fever? ☐ Yes ☐ No
3. Past history of Guillain-Barre Syndrome? ☐ Yes ☐ No
4. Are you pregnant? (in first trimester?) ☐ Yes ☐ No
5. Have you ever had a serious reaction to a flu vaccine before? ☐ Yes ☐ No
6. Have you received other immunizations in the past 2 weeks? ☐ Yes ☐ No
7. Are you immunocompromised? ☐ Yes ☐ No

Initial:

_____ I am free of any precautionary condition, or have attached a physician's statement requesting this vaccine be given to me.

_____ I have received and read the Vaccine Information Statement (VIS) on Influenza.

_____ I have read or have had the risks and benefits of the flu vaccine explained to me.

First Name: ______________________ **Last Name:** ______________________

Date of Birth: ______________ **Age:** ________ **Gender:** ☐ Female ☐ Male

Home Address: ______________________ **Phone Number:** ______________________

City: ______________________ **State:** __________ **ZIP Code:** __________

I want to receive the: **Quadrivalent Flu Vaccine**

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to medical staff at the drive-through vaccination clinic on Oct. 23, 2019, as applicable (each an "applicable Provider"), to administer the vaccine Flucelvax Quadrivalent. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the Quadrivalent. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's immunization registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my immunization information to the State Registry, to the State HIE, or through the State HIE, to the State Registry, for purposes of public health reporting or to my health care providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my immunization information to the State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form.

Patient signature: ______________________________ **Date:** __________
(Parent or guardian, if minor)

To be filled out by person administering vaccine:

Brand of Vaccine: ***Flucelvax Quadrivalent*** Lot # 259807 259810 259814

Expiration Date: 05/31/2020 or 06/2020 Dose: .5ml

Deltoid Injection Site: ☐ LEFT ☐ RIGHT

Immunizer: Initials: __________ **Date:** __________ **Time:** ______________