**Influenza Immunization Consent form**

Name: (Please Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€ I hereby give permission to administer the **[Insert Influenza Season Years]** inactivated influenza vaccine IM which is offered October through March of each year. I have read, received and understand the Vaccination Information Sheet (VIS) regarding the risks, benefits and side effects. I also acknowledge that there are no contraindications for me to receive the influenza vaccination. I also acknowledge that if an anaphylactic reaction to the influenza vaccine occurs, I consent to the administration of Epinephrine 1:1000 0.5 ml SQ STAT and 911 will be called for transport to the ER. I am aware that allergic reaction may occur minutes or hours after vaccination.

€ I decline to have the influenza vaccine at this time.

Reason for declination: € Received the vaccine at another location

€ Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by a representative, please identify your relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please place a checkmark next to the contraindication if it is applicable:

€ Have you ever had a severe reaction (such as anaphylaxis) to any component of the vaccine, including

egg protein, the preservative thimerosal used in multi-dose vials or following a previous dose of any influenza vaccine?

€ Are you ill or have a temperature?

€ History of Guillain Barre Syndrome (GBS) occurring 6 weeks after receiving an influenza vaccine.

€ If you have had recent chemotherapy, radiation, or steroids (except inhaled), these conditions may

decrease the effectiveness of the vaccine. Check with your physician before receiving.

Vaccine Administration Information

Manufacturer: Distributed by:

Lot Number: Expiration date:

Dose: 0.5 ml IM

Site: € L Deltoid € R Deltoid

Administered by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature/title