

Influenza Vaccine Administration Consent 2024

Name: _____

Date of Birth: _____

Employer: _____

Today's Date: _____

I have read or it has been explained to me the information about Influenza vaccines. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccines and consent to the vaccine being given to me or to the person named below for who I authorize this request.

Have you been sick in the last 24 hours? (Such as fever)	YES	NO
Have you had a transplant (including bone marrow) or are you a transplant candidate?	YES	NO
Have you ever had an adverse reaction to this or any other Influenza vaccine, latex, or thimerosal?	YES	NO
Have you ever had a serious reaction to eggs ?	YES	NO
Have you ever had Guillain-Barre Syndrome?	YES	NO
Are you pregnant or planning to become pregnant within the next 28 days or are you a nursing mother?	YES	NO

By signing below, you affirm that you have read and understand the Vaccine Information Sheet (VIS).

Signature or person to receive vaccine or parent/guardian: _____

******* OFFICE USE ONLY *******

Were all "YES" answers above reviewed by a provider?	YES	NO
Is this vaccine sponsored by the state as part of the VFC program?	YES	NO
Was a VIS given and the VIS publish date verified? Date on VIS that was given: _____	YES	NO
This is a Look-alike Sound-alike medication. Did you double verify the name of the medication on the label with medication ordered?	YES	NO
Who provided counseling to the patient/caregiver?	MA/RT/LPN	Provider
Was the patient instructed to wait in the clinic for 15 minutes after the shot was given?	YES	NO

Temperature prior to injection: _____

OFF SITE Location: _____

Manufacturer: _____

Lot: _____

NDC: _____

Expiration Date: _____

Route: _____ Site: R / L _____ Time: _____

Printed name of vaccine administrator: _____

Signature of vaccine administrator: _____ Date: _____