Healthline Medical Group
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INFLUENZA VACCINE CONSENT FORM

Please answer the following questions. If you answer YES to any questions below you should NOT receive the vaccine before discussing with your physician.

1.) Are you allergic to eggs or egg products?	___YES	___NO
2.) Are you ill with an active infection or cold, with or without fever?	___YES	___NO
3.) Do you have the tendency to faint?	___YES	___NO
4.) Are you pregnant?	___YES	___NO
5.) Do you have an immune compromising condition or disease?	___YES	___NO
6.) Are you currently taking chemotherapy?	___YES	___NO
7.) Do you have an active nerve disorder?	___YES	___NO
8.) Do you have a prior history of Guillain-Barre Syndrome ?	___YES	___NO

Mild or Severe Side Effects may include soreness at the injection site, fever, chills, headache and muscle soreness. Rarely the vaccine can cause a severe allergic reaction (itching, skin rash, difficulty breathing, swelling of the tongue). Notify the school nurse or your doctor immediately if you experience a severe reaction or if mild side effects persist longer than two days.

PLEASE PRINT:

Patient Name: _____

Date of Birth: _____ SS#_____

I have been informed about influenza and the influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and the risk of the influenza vaccine and request that it be given to me.

_____ Date: _____
Signature

OFFICE USE ONLY

Vaccination Administered on Date: _____ Dosage:_____ Site: ___R ___L Deltoid

Bottle #: _____ Expires: _____ Lot #: _____

Manufacturer: _____ Nurse Signature: _____