

FLU VACCINE QUESTIONNAIRE AND CONSENT

	name:	Date of Birth		Age:	
Do you have an allergy to eggs or poultry? Do you have any allergies to medications? Have you received the flu vaccine in the past? If yes, what was the approximate date of last dose? Have you ever had a reaction or problem with a flu vaccine? Were you ever paralyzed by Guillan-Bare Syndrome? Do you or a family member currently have a moderate or severe illness? yes no Did you receive a Vaccine Information Statement? Wes no By signing below, I acknowledge the following: I have read the information in the "Vaccine Information Statement" on the Influenza vaccine. I understand the risks and benefits associated with the influenza vaccination, and my questions have been answered. I wish to receive the influenza vaccine. Signature: (must be signed by parent if under 19 years of age) For office use only Fluzone Quad- Fluzone High Dose Quad- VFC Flulaval Quad-GLAXO SMITHKLINE Lot: 24BM2 Exp:06/30/22 NDC:19515-818-41 0.5mL VFC FluMist Quad, Intranasal-ASTRAZENECALot:NH3062 Exp:12/14/2021NDC:66019-308-01 0.2mL Site: left or right thigh or deltoid					
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Administering Clinician's Signature Date:	Site: left or right thigh or deltoid				
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