FLU VACCINE QUESTIONNAIRE AND CONSENT

Name:____Date of Birth________________Age:_______

Please answer the following questions:

Do you have an allergy to eggs or poultry?	yes	no
Do you have any allergies to medications?	yes	no
Have you received the flu vaccine in the past?	yes	no
If yes, what was the approximate date of last dose?_____________________		
Have you ever had a reaction or problem with a flu vaccine?	yes	no
Were you ever paralyzed by Guillan-Bare Syndrome?	yes	no
Do you or a family member currently have a moderate or severe illness?	yes	no
Did you receive a Vaccine Information Statement?	yes	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:____ Date:_____________________

(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-ASTRAZENECA	Lot:NH3062	Exp:12/14/2021	NDC:66019-308-01	0.2mL

Site: left or right thigh or deltoid

Administering Clinician’s Signature_____________________________________Date:____________________