Alameda Acute Care Clinic & Family Medicine

INFLUENZA VACCINATION CONSENT FORM

Patient Information:

First Name: _____Middle:_____Last name:_____

Screening for influenza vaccine eligibility:

1. Do you have a severe allergy to eggs? (circle one) Yes No
2. Have you ever had a life-threatening reaction to the influenza vaccine? Yes No
3. Do you have a history of Guillain-Barre Syndrome? Yes No
4. Are you moderately or severely ill today? Yes No

If yes to any questions 1-3 then DO NOT vaccinate with influenza vaccine.
If yes to question 4, vaccinate when resident has recovered.

I have read or had explained to me the Vaccination Information Statement about influenza vaccination and I understand the benefits and risks of influenza vaccination. I request that the influenza vaccination be given to me (or the person named above for whom I am authorized to make this request).

Signature: _____ Date: _____

Name:_____Relationship to patient: _____

To be completed by person administering vaccine:

Today's date:_____Site of Injection (circle one): R L
Lot #:_____Expiration Date: _____
Medical Record #:_____Room #: _____
Administered by: _____