Immunization Consent Form and Patient Record **SSN# _____**

The following questions will help us determine if the HD flu vaccination is appropriate to be given today. If a question is not clear, please ask your health care provider to explain it.

Questions	Yes	No	I don't know
1. Are you sick today?			
2. Do you have allergies to medications, food (egg), or any vaccine?			
3. Do you have a seizure, brain, or other nervous system problems?			
4. Have ever had a serious reaction after receiving a vaccination?			
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?			
6. Do you take Cortisone, Prednisone, other steroid, or anticancer drugs, or have you had x-ray treatments?			
7. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune globulin?			
8. For women: are you pregnant or is there a chance you could become pregnant during the next month?			
9. Have you received any vaccination in the past 4 weeks?			

Consent for Administration of Influenza Vaccine:
I have read, or have had read to me, the information regarding the influenza vaccine and have been given a copy of the influenza vaccination information statement. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine. I consent to, or give consent for, the administration of the influenza vaccine. I understand that I have to remain in the facility for 15 minutes following the vaccine administration.

Name of patient (Print) **Date of Birth**

Signature of patient **Primary care practitioner (Doctor)**

Patient Address **Patient Cell phone number**

Date of Vaccination: 11/18/21 RX#: _____

Site of Vaccination: Right Arm Left Arm VIS Date: 8/06/2021

Vaccine Manufacturer: Sanofi Pasteur (49281-0635-15) Lot Number: UJ711AB

Expiration Date: 06/30/2022 Dose of Vaccination: 0.5ml

Name and Signature of administrator & credentials: Kevin Musto