TriHealth Physician Partners

2020-21 Influenza Immunization Consent Form

_____ _____/_____/_____ _____

Name of person receiving vaccine (please print) DOB Age

_____

Street Address City State Zip

Insurance_____

If patient is receiving the <u>REGULAR VACCINE</u> please complete:

Have you ever had any of the following:

Yes No

□ □ Life-threatening reaction to eggs, such as trouble breathing
□ □ Life-threatening reaction to a previous flu shot, such as trouble breathing
□ □ Guillain-Barre` Syndrome within 6 weeks of receiving a flu shot
□ □ Bone Marrow transplant within the past 6 months
□ □ Anaphylactic latex allergy
□ □ Previous immunization this flu season

<u>If you answered yes to any of the above, you may not receive a flu shot this year.</u>

□ □ Do you currently have a high fever?
(If so, you should wait until you have recovered before receiving a flu vaccine)

I have truthfully answered all of the questions on this form. I have also received a copy of the Vaccine Information Statement. My signature below indicates my permission for the vaccine to be administered to me.

_____

Signature of person receiving vaccine or Parent/Guardian

- Influenza Virus Vaccine, quadrivalent (IIV4),.5 ml, IM (6 months and older)

Lot # _____ Manufacturer _____

Site _____ Date _____/_____/_____

Administered by: _____

Name, Clinical Title

DATE:_____