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 Sanofi Pasteur	☐ Fluzone High Dose Sanofi Pasteur	☐ VFC Fluzone Quad Sanofi Pasteur	☐ VFC Flumist Quad Med Immune
49281-637-15	49281-122-65	49281-422-50	66019-309-10
Lot: UJ878AA	Lot: UT7715BA	Lot: UT7683JA	Lot: PH3533
Exp: 06/30/2023	Exp: 06/30/2023	Exp: 06/30/2023	Exp: 12/14/2022
Dose: 0.5mL	Dose: 0.7mL	Dose: 0.5mL	Dose: 0.2mL

Circle correct site information: Left or Right Thigh or Deltoid Intranasal

Administering Clinician:_____Date:_____