Seasonal Influenza Vaccine Registration/Consent Form

Patient Name: _____ Date of Birth: _____

Street Address: _____

_____

Best Contact Telephone Number: ☐ Home / ☐ Work / ☐ Cell _____

Please read and sign where indicated to give your consent to receive the influenza vaccine.

I understand that persons with certain medical conditions should NOT receive the influenza vaccine. Those conditions include:

- Previous allergic reaction to the influenza vaccine
- Guillain-Barre Syndrome
- Allergy to eggs
- Illness involving fever (temperature of/or more than 100.5) in the past 24 hours
- Children less than 9 years of age

I/my child do NOT have any of these medical conditions listed above.

I agree to wait in the lobby for 15 minutes following my injection so that I may be monitored for possible reaction(s) to the influenza vaccine.

I understand that the influenza vaccine is for the prevention of influenza only and may not fully protect me from influenza for the first 14 days after receiving the shot, that the seasonal influenza vaccine must be repeated each year and that receiving the influenza vaccine does not guarantee that I will develop immunity to influenza.

I have been informed and understand that possible side effects of the influenza vaccine that include:

- Pain or redness at the site of the injection
- Joint pain, body aches and/or low-grade fever developing within 6-12 hours after the injection and can last for 1-2 days.

I have been informed that severe effects such as fever of/or more than 101, behavior changes or trouble breathing are very rare. If any severe symptoms develop, I agree to get to a medical facility immediately to be checked and treated. I have been given a patient education handout regarding the influenza vaccine today.

Patient Name (print): _____

Patient/Authorized Person Signature: _____ Date: _____

Person Authorized to Give Consent, if not patient (print): _____

Relationship to Patient: _____

HealthPOiNT Clinic Staff: 1) A copy of current and valid photo ID is required from signing Parent/Guardian.
2) Scan this document into Patient Docs with the following naming format:
YYYYMMDD_LASTNAME, FIRSTNAME, DOB (MM/DD/YYYY)

Revised: 01/03/2013
Approved: 01/08/2013