

Nursing Vaccination Specialists, Inc.
Influenza Vaccination Consent Form
(Inactivated)
 2009-2010 Season

Last Name:	First:	MI:
Address:		
City:	State:	Zip:
Phone:	Birthdate:	Age:
Physician:		

Open clinic **Employee** **Spouse** **Contractor** **Student/Family** **Other** _____

Please answer the following questions:

Yes No

1.	Have you ever had Guillain-Barre syndrome? (A viral illness resulting in neurological symptoms including paralysis)		
2.	Are you sick or do you have a fever today? (If yes, you should not receive the vaccine)		
3.	Have you ever had a serious allergic (anaphylactic) reaction to eggs?		
3a.	I have a known allergy to eggs and want to receive the flu vaccine. The risks have been explained to me.		
4.	Have you ever received a flu shot before?		
5.	Are you pregnant?		

I have read or had explained to me the above information about the influenza vaccine and have truthfully answered all the questions on this form. I have also received a copy of the Vaccine Information Statement for the influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccination for influenza and request that the influenza vaccine be given to me or to the person named above for whom I am authorized to make the request.

Printed Name

Signature

Date

FOR OFFICE USE ONLY:

Vaccine	Date	Manufacturer	Lot #	Exp Date	Dose	Inject Site	Admin By
Influenza							

RW Voucher _____

Cash \$ _____

Check \$ _____ # _____

MC/Visa \$ _____

If under the age of 9:

_____ 1st shot

_____ 2nd shot