

Consent for Flu Vaccine

Name: _____ DOB: _____ DATE: _____

1. Do you have a history of severe allergic reactions to vaccine? Yes___ No___
2. Any prior history of allergic reactions to egg and/or gelatin? Yes___ No___
3. Do you have sensitivity to preservative Thimersol? Yes___ No___
4. Do you have past history of Guillan Barre Syndrome? Yes___ No___
5. Do you currently have a fever?
Are you moderately or severely ill? Yes___ No___
6. Have you ever had a a severe reaction to latex? Yes___ No___
7. Was vaccine information given and explained to you? Yes___ No___

I have read/had explained to me information about the illnesses and the vaccines listed above for which I' am being vaccinated. I understand the benefits and risks of the vaccines to be given to me and by signing below I give permission to proceed.

Vaccine Administrator's Signature: _____

Today's Date: _____

Patient's Signature: _____