GRAPE TREE
MEDICAL STAFFING

Influenza Immunization Consent Form

Name (Please Print)	Date of Birth	Sex	County of Residence
Address	City	State	ZIP
Phone	For Persons Under 19 Years Old, Mother's Maiden Name		
	Doctor's Name		
	Doctor's Address		
	Clinic/Office Site Where Vaccine Administered		NYSIIS Permission ≥ 19 Years Old ☐ No ☐ Yes

☐ No ☐ Yes Are you (your child) currently sick with a fever?
☐ No ☐ Yes Do you (your child) have a severe allergy to eggs, latex or an ingredient of the flu or pneumococcal vaccine?
If yes, which? ______
☐ No ☐ Yes Have you (your child) ever had Guillain Barré syndrome?
☐ No ☐ Yes Is this your (your child's) first time getting the flu vaccine?
☐ No ☐ Yes Have you (your child) had any vaccine within the last 28 days?
If yes, which vaccine? ______ Date? ______
☐ No ☐ Yes Have you ever had a pneumonia shot?
If yes, when? ______
☐ No ☐ Yes Are you (your child) a smoker or do you (your child) have a chronic medical condition such as asthma, heart or lung disease?
If yes, please indicate "smoker" or name of chronic disease. ______
☐ No ☐ Yes Are you (your child) pregnant?
☐ No ☐ Yes For children 2-4 years: Has your child had asthma or wheezing episodes in the last year?
☐ No ☐ Yes Have you (your child) taken antiviral medication to prevent the flu within the last 48 hours?
☐ No ☐ Yes Is your child or adolescent receiving long-term aspirin treatment?
☐ No ☐ Yes Are you (your child) currently receiving radiation, chemotherapy, or immunosuppressive therapy?
☐ No ☐ Yes Do you (your child) have close contact with anyone with a severely weakened immune system?

Influenza Consent

I have read, or had explained to me, the Vaccine Information Statement about **influenza** vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the **influenza** vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

______

Signature of Recipient (Parent or Guardian) Date

Influenza Vaccine

Administration Date ______

Administration Site ☐ Left Arm ☐ Right Arm
☐ Left Thigh ☐ Right Thigh

Dosage ☐ 0.5 ml ☐ 0.25 ml ☐ LAIV

Manufacturer & Lot Number ______

VIS Date ______

Nurse Signature ______

Next Immunization Due: ☐ Next Year ☐ In 4 Weeks ☐ Other ______