SELTZER FAMILY
BLOOMSBURG, PA
The Medicine Shoppe

Influenza Vaccine Consent Form

Name: _____ **Date**: _____

Date of Birth: _____ **Age**: _____ **Phone Number**: _____

Address: _____

Name of Primary Care Physician: _____

Date of last Influenza vaccine: _____ ☐ Unknown ☐ Never received

1.	Have you ever had any medication, vaccine, or latex allergy? List all allergies: _____	Yes	No
2.	Have you had Guillain-Barre syndrome related to a previous vaccine?	Yes	No
3.	Do you currently have an acute illness or infection?	Yes	No
4.	Are you on anticoagulation therapy or have a bleeding disorder?	Yes	No
5.	Have you received any vaccines in the last 4 weeks?	Yes	No
6.	Do you have a history of seizures?	Yes	No
7.	Women: Are you or might you be pregnant?	Yes	No

If you answered yes to any of the above, you should NOT get a flu shot today.

CONSENT:
I have read the above information and understand the risks and benefits of receiving this vaccine as stated in the VIS. I had the opportunity to ask questions regarding the influenza vaccine. I request the vaccine to be given to me.

Signature: _____ Date: _____

Circle one: *Flucelvax / Afluria / Fluad* / Fluzone HD / Flumist *(Sticker)*

Date of Vaccination: _____ Site: 0.5 mL IM ☐ Right Deltoid ☐ Left Deltoid

Manufacturer: _____ Lot #:_____ Expiration Date: _____

Administered by: (Signature) _____