PHCTR

Flu Vaccine Questionnaire and Consent

PATIENT NAME: ____ **DOB**: ________________

Please circle Yes or No for EVERY statement below:

Yes	**No**	I have had a previous allergy or reaction to the flu vaccine.
Yes	**No**	I am allergic to eggs or thimerosal.
Yes	**No**	I have a history of Guillain-Barre Syndrome.
Yes	**No**	My current health status is moderately / severely ill.
Yes	**No**	I had a fever within the past 48 hours.
Yes	**No**	I have planned chemotherapy / immunosuppressive therapy within the next 2 weeks.
Yes	**No**	There is a possibility I am pregnant.

I have read and understand the Influenza Vaccine Information sheet provided to me. All of my questions about the vaccine have been answered.

____ ___________________________
Patient/Guardian signature Date

____ ___________________________
Witness signature Date

For Health Center use only:

FDLMP: _______________ Allergies: ___________________________ Temp: ________________

Date: __________________ Time: ______________________________ Site: _________________

Manufacturer: ___________ Lot #: ______________________________ Exp: _________________

____ ___________________________
Nurse signature Date

2012