Nursing Vaccination Specialists, Inc.
Influenza Vaccination Consent Form
(Inactivated)

Last Name ____________ First ____________ MI ____

Address ____________

City ____________ State ____________ Zip ____

Phone ____________ Birthdate ____________ Age ____

Physician ____________

Please circle YES or NO for each question.

Yes	No	Have you ever had Guillain-Barre syndrome? (A viral illness resulting in neurological symptoms including paralysis)
Yes	No	Are you sick or do you have a fever today? (If yes, you should not receive the vaccine)
Yes	No	Have you ever had a serious allergic (anaphylactic) reaction to eggs?
Yes	No	Have you ever received a flu shot before?
Yes	No	Are you pregnant?
Yes	No	Do you have a latex allergy?

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.

For those that have any contraindication to receive the influenza vaccine, i.e., egg allergy, it is the policy of Nursing Vaccination Specialist's, Inc. that you present a physician order prior to administration.

Printed Name ____________ Signature (Parent/Guardian Signature if under 18 years of age) ____________ Date ____

For Office Use Only

○ Open Clinic ○ Employee ○ Spouse ○ Contractor ○ Student/Family ○ Other ____________

Dose
- ○ #1
- ○ #2

Vaccine Administered
- ○ IM (From 10 dose vial)
- ○ IM Adult Preservative Free
- ○ IM Pediatric Preservative Free

Site Administered
- ○ Left Deltoid
- ○ Right Deltoid
- ○ Left Thigh
- ○ Right Thigh

Manufacturer
- ○ Medimmune
- ○ GlaxoSmithKline
- ○ Sanofi Pasteur

_____ / _____ / _____
Expiration Date

____
Lot Number

_____ / _____ / _____
Date Vaccinated

____
Administered by / Title

Voucher ____________ Cash/Check $ ____________ MC/Visa $ ____________