# 65 OVER FLU VACCINE CONSENT FORM

**Screening checklist for Contraindications to Inactivate Injectable Influenza Vaccination:**

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child an inactivated influenza vaccination today. If you answer "yes" to any questions, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

| | Yes | No | Don't know |
|---|---|---|---|
| 1. Is the person to be vaccinated sick? | ☐ | ☐ | ☐ |
| 2. Does the person to be vaccinated have an allergy to a component of the vaccine? | ☐ | ☐ | ☐ |
| 3. Has the person to be vaccinated ever had a serious reaction to an influenza vaccine in the past? | ☐ | ☐ | ☐ |
| 4. Has the person to be vaccinated ever had Guillian-Barré syndrome? | ☐ | ☐ | ☐ |

I have read the Vaccination Information Sheet (VIS) or had had explained to me the information about the 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 vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

Name: _____
Last First MI

Date of Birth: _____ Contact number: _____

Email Address: _____

Signature of person to receive vaccine or person authorized to make the request:

X_____ Date: _____

**FOR CLINIC USE ONLY**

**65 OVER FLU VACCINE**

SITE: **Left Deltoid** **Right Deltoid** Manufacturer: **SEQIRUS**

Lot#: Expiration Date:

Signature:_____Date:_____