HEALTH CARE PROVIDER INFLUENZA VACCINE CONSENT FORM

clinic stamp

Last name: _____ First name: _____ Phone number: _____

Street Address: _____ City: _____ Postal Code: _____

Male ☐ Female ☐ Date of Birth: Year _____ Month _____ Day _____ Age: _____

For children 6 months of age to less than 9 years of age who have NOT been previously vaccinated with **seasonal** influenza vaccine, is this the first or second dose of seasonal influenza vaccine this year?

First ☐ Second ☐ If second, please indicate the date of the first dose: _____/_____/____ (year, month, day)

Are you feeling ill today?	**No ☐**	**Yes ☐**	**If yes, please explain below**
Have you ever had an allergic reaction to a vaccine?	No ☐	Yes ☐	If yes, please explain below
Are you allergic to:			
• **Thimerosal? (multi-dose vials only)**	No ☐	Yes ☐	If yes, please explain below
• **Neomycin? (Afluria Tetra only)**	No ☐	Yes ☐	If yes, please explain below
• **Polymyxin B (Alfuria Tetra only)**	No ☐	Yes ☐	If yes, please explain below
Do you have a bleeding disorder?	No ☐	Yes ☐	If yes, please explain below
Are you on any medication that could affect blood clotting?	No ☐	Yes ☐	If yes, please explain below
Have you ever been diagnosed with Guillain-Barré Syndrome?	No ☐	Yes ☐	If yes, please explain below
Have you ever been diagnosed with Oculorespiratory Syndrome?	No ☐	Yes ☐	If yes, please explain below
Please explain and "yes" answers provided above:			

I consent to receiving the seasonal influenza vaccine.

If signing for someone other than yourself, indicate your relationship to that other person: _____

If signing for someone other than myself, I confirm that I am the parent / legal guardian or substitute decision maker.

Signature**:** _____ Print**:** _____

Date of signature: _____

For Clinic Use Only:

☐ 1 ½" needle

VACCINE	DOSE	LOT NUMBER	EXPIRY DATE	SITE / IM	TIME GIVEN	DATE GIVEN	GIVEN BY
	0.5 ml						

Comments: _____