



## FLU VACCINE QUESTIONNAIRE AND CONSENT

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_

Please answer the following questions:

Do you have an allergy to eggs or poultry?	yes	no
Do you have any allergies to medications?	yes	no
Have you received the flu vaccine in the past?	yes	no
If yes, what was the approximate date of last dose? _____		
Have you ever had a reaction or problem with a flu vaccine?	yes	no
Were you ever paralyzed by Guillan-Bare Syndrome?	yes	no
Do you or a family member currently have a moderate or severe illness?	yes	no
Did you receive a Vaccine Information Statement?	yes	no

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By signing below, I acknowledge the following:

I have read the information in the "Vaccine Information Statement" on the Influenza vaccine. I understand the risks and benefits associated with the influenza vaccination, and my questions have been answered. I wish to receive the influenza vaccine.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(must be signed by parent if under 19 years of age)

For office use only

Fluzone Quad-Sanofi Pasteur Lot:UJ475AB Exp:06/30/21 NDC:49281-633-15 0.5mL

Fluzone High Dose Quad-Sanofi Pasteur Lot:UJ483AB Exp:06/30/21 NDC:49281-120-88 0.7mL

VFC Flulaval Quad-Biomedical Corp of Quebec Lot:494S5 Exp:06/30/21 NDC:19515-816-41 0.5mL

VFC FluMist Quad, Intranasal-MedImmune, LLC Lot:MH2201 Exp:12/16/20 NDC:66019-307-01 0.2mL

Site: left or right                      thigh or deltoid

Administering Clinician's Signature \_\_\_\_\_ Date: \_\_\_\_\_