# HEALTH CARE PROVIDER INFLUENZA VACCINE CONSENT FORM 2022-2023

*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 a serious or an allergic reaction to a vaccine?** | No ☐ | Yes ☐ | If yes, please explain below |
| **Are you allergic to:**<br>• **thimerosal? (multi-dose vials only)**<br>• **Kanamycin and/or Neomycin? (Fluad 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:**<br>• **Guillain-Barré Syndrome?**<br>• **Oculorespiratory Syndrome?** | No ☐<br>No ☐ | Yes ☐<br>Yes ☐ | If yes, please explain below<br>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 |
|---|---|---|---|---|---|---|---|
| | **__ ml** | | | | | | |

Comments: _____