ASSOCIATES IN FAMILY MEDICINE

AFM Flu Vaccination Consent Form

1. Are you allergic to egg involving symptoms other than hives? - Such as angioedema, respiratory distress, lightheadedness, or recurrent vomiting Required epinephrine or another emergency medical treatment	Yes	No
2. Have you ever had a serious reaction to a flu vaccine?	Yes	No
3. Do you have a history of Guillain-Barre syndrome?	Yes	No
4. Are you allergic or sensitive to latex?	Yes	No
5. Are you sick today?	Yes	No
6. Do you have a history of a serious vaccine reaction?	Yes	No

I have been provided a copy of the appropriate CDC Vaccine Information Statement(s) and have read, and/or been informed, about the vaccine(s) being administered today. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccination(s) and request that the vaccine(s) be given to me or to the person named below for whom I am authorized to make the request.

Signature of patient (or parent/guardian) _____ Date _____

Printed name of patient _____ Date of Birth of patient _____

OFFICE USE ONLY:

Place vaccine labels here along with site of vaccine placement

Fluarix & Flulaval (#43)

Flublok (#75)

High Dose (#250)

VIS Date: 8/6/2021

Administered by: Date:

Double check by:

EDI STICKER