ACADIANA URGENT CARE CENTER

Influenza Vaccine Consent Form 2015-2016

SECTION A: INFORMATION		
Name (Last, First, Middle):		
Date of Birth: / /	Age (3&older):	Gender: M F

SECTION B: HEALTH HISTORY - please check yes or no for each question.	YES	NO
1. Have you ever had a serious allergic reaction ro eggs?		
2. Are you allergic to THIMEROSOL?		
3. Do you have Guillain-Barre syndrome (GBS)?		
4. Are you currently pregnant or a nursing mother?		
5. Are you taking a theophylline preparation (asthma med) or warfarin sodium (blood thinner)?		
6. Are you currently ill or have an elevated temperature?		
7. Have you fainted following any type of injection?		
8. Have you ever had a severe reaction after a dose of influenza vaccine?		
9. Do you have any allergies (including latex, food and medications? Please list below:		
10. Additional comments:		

SECTION C: CONSENT FOR VACCINATION	
I have read both the Recommendations and the Warnings and side Effects for the Intranasal Influenza Vaccine Information sheets. I have had the opportunity to ask questions and understand the benefits, risks, and possible side effects of the intranasal influenza vaccine. I have been given the opportunity to consult with my personal physician prior to administration. I also understand that there is no guarantee that I will not contract influenza or experience adverse side effects from this vaccine. I hearby give my consent for the intranasal influenza vaccine to be administered, 0.2 ml (standard dose), intranasal to me.	
Signature:	Date: / /
Parent/Legal Guardian Print Name:	Relation:
Witness Signature:	Date: / /

FOR OFFICE USE ONLY - recommended for age 3 & Older	LOCATION: ON-SITE OFF-SITE
Manufacturer:	Lot Number:
Site of Injection - Deltoid: R L	Temp:
Administered by:	Date: / / Time: