



Occupational Medicine and Urgent Care: Influenza (Flu) Vaccine Consent - Patient to Complete Shaded Area

Your AHS Walk-In Clinic Team appreciates the opportunity to handle your health care needs. Please review carefully the questions and information below.

Please answer the following questions:

Yes No

1. Are you allergic to eggs or egg products?

2. Have you ever had or been diagnosed with Guillain-Barre' Syndrome?

(a severe paralytic illness, also called GBS)

3. Are you sensitive to thimerosal? (a substance used as an antiseptic and germ killer)

4. Do you have an active nerve disorder?

5. Do you currently have a fever, active respiratory illness or other infections?

6. **Women Only:** Are you currently pregnant or think you might be pregnant?

I have read or have had explained to me information about the Influenza Virus Vaccine. I have had a chance to ask questions that were answered to my satisfaction. I have been provided the vaccine information statement from the CDC on applicable vaccine. I understand the benefits and risks of each vaccine administered and ask that the vaccine be administered to me by the provider listed above.

Patient Information (please print):

Name:

Date of Birth:

Address:

City:

Date: Signature:

Clinic Use Only:

Date Administered:

Vaccine Manufacturer:

Lot Number: Expiration Date:

Site of Injection: Left Right Deltoid

Provider Signature: