## *FLU VACCINE CONSENT FORM*

**Client Name**: _____ **Date of Birth**: _____

*(please print)* *Last* *First* *Middle Initial* *AGE:* _____

If any of the following health screening questions are not clear, leave it blank and a healthcare worker will explain it to you.

| **Check each box YES or NO** | YES | NO |
|---|---|---|
| 1. Is the client sick today? If YES, please explain: | | |
| 2. Does the client have a serious allergy to eggs? | | |
| 3. Does the client have any other serious allergies to medications, food, latex, or any vaccines? | | |
| 4. Has the client ever had a serious reaction to a previous dose of flu vaccine? | | |
| 5. Has the client ever had Gullian-Barré syndrome (type of temporary severe muscle weakness) within 6 weeks of receiving flu vaccine? | | |
| 6. In the past 4 weeks has the client received any of the following vaccinations? (please circle) MMR Varicella Nasal Flu | | |
| 7. Does client have any of the following: recurrent wheezing, asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidney, liver, nerves, or blood? | | |
| 8. Is client on long-term aspirin or aspirin-containing therapy (example: daily dose of aspirin)? | | |
| 9. Does the client have a weakened immune system (examples: from cancer, leukemia, AIDS, or on medications for steroids or cancer)? | | |
| 10. Is female client pregnant? | | |
| 11. Does client have close contact with a person who needs care in a protected environment (example: someone who has recently had a bone marrow transplant)? | | |
| 12. Has client taken any influenza antiviral medications in the last week (example: Tamiflu, Relenza)? | | |
| 13. Has your child received the 1st dose of H1N1 vaccine? If yes, please list date and form. Date received: month _____ day _____ year _____ Form (please circle) nasal spray shot | | |

## My signature below proves:

- I have read or had explained to me the Vaccine Information Statement for the seasonal / H1N1 Influenza vaccine and understand the risks and benefits.
- I consent to the administration of the seasonal / H1N1 vaccine to me or to the person for whom I am authorized to make this request.
- I verify that all of the above information I supplied is correct to the best of my knowledge.
- I have received the HIPAA privacy notice.

_____ _____

Signature of Client or Representative Relationship to Client (if Representative)

_____ _____/_____/_____

Printed Name (if Representative) Date Signed

## For Office Use Only (do not write in this box)

**Healthcare provider comments:**

## Refusal to Consent to Vaccination

I have received the Vaccine Information Statement and understand the purpose, risks and benefits, and possible consequences of not receiving seasonal /H1N1 vaccination. I understand that I may change my mind later, accept full responsibility for any consequences of not being vaccinated, and acknowledge that I have read and understand this statement.

_____ ____/____/____ _____ ____/____/____

**Signature of Client or Representative** **Date Signed** **Signature of Healthcare Worker (if present)** **Date Signed**