

2018-2019 Influenza Consent Form

Employee Name:

Date of Birth:

Address: Phone:

Insurance:

Insurance ID #:

Please answer the following questions prior to vaccination:

1. Are you feeling ill today? Yes No
2. Do you have an allergy to eggs? Yes No
3. Have you ever had a serious reaction to the influenza vaccine in the past? Yes No
4. Have you ever had Guillian-Barre’ Syndrome? Yes No

Signature: Date:

Influenza Vaccine Site:

Vaccine Manufacturer: Vaccine Lot Number:

Expiration Date:

Signature of person administering vaccine:

Name of person administering vaccine:

Epinephrine administered: Yes No Location:

