Last updated 10/2021

INFLUENZA VACCINE CONSENT & ADMINISTRATION FORM
2021 – 2022 FLU SEASON

Patient Name (Print Clearly):_____DOB:_____/_____/_____Age:_____

Phone Number: (_____)_____-_____Primary Care Physician Name: _____

Review the statements below and **check those that apply to you**:

- ☐ I am allergic to eggs or egg products.
- ☐ I am sensitive to Thimerosal (a preservative used in some vaccines).
- ☐ I have a history of the neurologic disorder Guillain-Barré Syndrome.
- ☐ I currently have a fever, acute respiratory or other active infection or illness.
- ☐ This is my first ever flu vaccine and I am under 8 years old (requires booster after 28 days from first dose).
- ☐ None of the above.

I understand that the cost of the vaccine is $30

I am paying via

- ☐ **Credit card**
- ☐ **Cash**

----------STOP: FOR INTERNAL USE ONLY----------

☐ Afluria Quadrivalent Seqirus 0.5ml ☐ Afluria Quadrivalent Seqirus (6 months-35 months old) 0.25ml	Intramuscular Injection Given: ☐ Left Deltoid ☐ Right Deltoid ☐ Payment collected by _____
Administered By (Full name and Title):	*Date of Vaccine:*