INFLUENZA VACCINE CONSENT FORM AND ADMINISTRATION RECORD

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

PLEASE CIRCLE YOU ANSWER TO THE FOLLOWING QUESTIONS:

1.	Have you received the flu vaccine before?	NO	YES
2.	Did you have any problems with the previous flu shots?	NO	YES
3.	Do you have any allergies to eggs or Thimerosol preservative?	NO	YES
4.	Are you ill today?	NO	YES
5.	Do you have a history of Guillain-Barre Syndrome?	NO	YES

Information about person to receive vaccine (Please Print)

_____

Name: First Last MI Birthdate Age

_____

Mailing Address: City State Zip Code

ImMTrax Consent Form

I authorize my health care provider and a public health agency to collect and enter my/my child's immunization records into the Dept. of Public Health and Human Services Immunization Information system. The IIS is a may be released to a public health agency as well as my health care providers to assist in my/my child's medical care and treatment. In addition, information may be released to childcare facilities and schools in which my child is enrolled to comply with state immunization requirement. I understand that I can revoke this authorization and have my/my child's record removed at any time *by contacting my local health department.*

Primary Policy Holder Date of Birth: _____

X_____

SIGNATURE of person to receive vaccine or person authorized to make request

OFFICE USE ONLY: ↓

Medicare # _____ Medicaid # _____

Insurance _____ VFC Eligibility _____ Paid _____

Vaccine Manufacturer & Lot Number _____ Site of Injection _____

_____

Vaccinator Signature Date