



Influenza Vaccine Consent Form

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Phone Number: _____

Address: _____

Name of Primary Care Physician: _____

Date of last Influenza vaccine: _____ ☐ Unknown ☐ Never received

- | | | |
|--|-----|----|
| 1. Have you ever had any medication, vaccine, or latex allergy? | Yes | No |
| List all allergies: _____ | | |
| 1. Have you had Guillain-Barre syndrome related to a previous vaccine? | Yes | No |
| 2. Do you currently have an acute illness or infection? | Yes | No |
| 3. Are you on anticoagulation therapy or have a bleeding disorder? | Yes | No |
| 4. Have you received any vaccines in the last 4 weeks? | Yes | No |
| 5. Do you have a history of seizures? | Yes | No |
| 6. Women: Are you or might you be pregnant? | Yes | No |

If you answered yes to any of the above, you should NOT get a flu shot today.

CONSENT:

I have read the above information and understand the risks and benefits of receiving this vaccine as stated in the VIS. I had the opportunity to ask questions regarding the influenza vaccine. I request the vaccine to be given to me.

Signature: _____ Date: _____

Circle one: *Flucelvax /Fluzone/ Fluzone High Dose* (Sticker)

Date of Vaccination: _____ Site: 0.5 mL IM ☐ Right Deltoid ☐ Left Deltoid

Manufacturer: _____ Lot #: _____ Expiration Date: _____

Administered by: (Signature) _____



Attention: Dr. _____ Fax: _____

The following patient has received a **2026-2027 Influenza** vaccine.

<i>Date</i>	<i>Patient</i>	<i>Date of Birth</i>

Thank you,

The Medicine Shoppe Pharmacy