

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 YOUR ANSWER TO THE FOLLOWING QUESTIONS:

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|--|----|-----|
| 1. Have you received the flu vaccine before? | NO | YES |
| 2. Did you have any problems with previous flu shots? | NO | YES |
| 3. Do you have any allergies to eggs or Thimerosal 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 _____
Phone: _____		Race: _____	Hispanic _____	Non-Hispanic _____

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 confidential, computer system that contains immunization records. I understand that information in the registry 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 child care facilities and schools in which my child is enrolled to comply with state immunization requirements. 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.

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

Medicare # _____	Medicaid # _____
Insurance _____	VFC Eligibility _____
Vaccine Manufacturer & Lot Number _____	Paid _____
Site of Injection _____	
Vaccinator Signature _____	Date _____