

# Memorial Health Care Systems

## Seward/Milford/Utica

### Community Influenza Vaccine Consent

Printed Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physician: \_\_\_\_\_

Attach copy of insurance card(s)

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever had Guillian-Barre Syndrome within 6 weeks of taking a flu shot?
<input type="checkbox"/>	<input type="checkbox"/>	2. Have you ever had a serious or life-threatening reaction to the influenza vaccine?
<input type="checkbox"/>	<input type="checkbox"/>	3. Do you have a fever or are you seriously ill today?

If you have checked "yes" to one of the above questions, you are **NOT** able to receive the flu shot at this time.

<input type="checkbox"/>	<input type="checkbox"/>	4. Do you experience symptoms other than hives after exposure to egg (such as angioedema, respiratory distress, lightheadedness, recurrent emesis)?
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If you have checked "yes" to question 4, you may receive any licensed and recommended influenza vaccine that is otherwise appropriate. The vaccine should be administered in an inpatient or outpatient medical setting and you should be supervised for 30 minutes following the vaccination by a health care provider who is able to recognize and manage severe allergic reactions.

### Special Health Conditions

If you have had recent chemotherapy, radiation therapy or steroids (except inhaled), these conditions may decrease the effectiveness of the vaccine. However, flu vaccination is still encouraged. You may wish to visit with your physician prior to receiving the vaccine. Flu vaccination is recommended for any woman who will be breastfeeding during the influenza season, or will be pregnant during the influenza season. Vaccination can occur in any trimester.

- YES, I have reviewed the influenza vaccine information statement and had my questions answered and I would like to have the influenza vaccine given to me.**
- I have had a severe allergic reaction to eggs and prefer that I receive the RIV4 (recombinant influenza vaccine, quadrivalent) influenza vaccine.**

**Recipient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Site: <input type="checkbox"/> 0.5ml IM <b>Left</b> deltoid <input type="checkbox"/> 0.5ml IM <b>Left</b> anterior thigh <input type="checkbox"/> 0.25ml IM <b>Left</b> anterior thigh	<input type="checkbox"/> 0.5ml IM <b>Right</b> deltoid <input type="checkbox"/> 0.5ml IM <b>Right</b> anterior thigh <input type="checkbox"/> 0.25ml IM <b>Right</b> anterior thigh
Administered by: _____	
Date: _____ (sticker)	