CHI St. Joseph Outpatient Clinic
Influenza Vaccine Assessment & Consent Form 2016-2017

Information about person to receive vaccine:

Last Name:	First Name:	MI:
DOB:	Age:	Gender:

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS NOTIFY THE NURSE BEFORE IMMUNIZATION:

Have you ever had a reaction to the flu vaccine?	Yes or No
Did you receive the flu vaccine last year?	Yes or No
Have you received any other vaccinations in the last 2 weeks?	Yes or No
Are you allergic to eggs?	Yes or No
Have you been diagnosed with Guillain-Barre' syndrome?	Yes or No
Are you pregnant or a nursing mother?	Yes or No
Are you sick with a fever greater than 100 degrees Fahrenheit?	Yes or No
Do you have a history of a neurological/ seizure disorder (epilepsy, Multiple Sclerosis, Febrile Seizures, or Myasthenia Gravis)?	Yes or No
Are you currently taking an antibiotic for infection?	Yes or No

CONSENT AND RELEASE FOR INFLUENZA VACCINE

I have read the information regarding the influenza immunization. I have had an opportunity to ask questions, and my questions have been answered to my satisfaction. I understand the benefits and risks of Influenza immunization as described.

I understand the risks and benefits of the flu vaccination and I give my consent to the medical staff of St. Joseph Physician Associates (SJPA) to give me (or my child) a flu vaccination.

_______________________________________ Signature of vaccine recipient, parent of child, legal guardian

_______________________ Date

FOR CLINIC USE ONLY: **INFLUENZA**

Manufacturer:	**Lot #:** **Injection site:**
Expiration Date:	**Date of vaccination:**
Signature of vaccine administrator:	**Title of vaccine administrator:**