CHI St. Joseph Outpatient Clinic
Influenza Vaccine Assessment & Consent Form 2017-2018

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? *If yes: Date: What facility?*	Yes or No
Are you allergic to eggs?	Yes or No
Have you been diagnosed with Guillain-Barre' syndrome after receiving the flu vaccine?	Yes or No
Are you sick with a fever greater than 100 degrees Fahrenheit?	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 CHI St. Joseph Medical Group (SJMG) to give me (or my child) a flu vaccination.

_____ _____

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

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FOR CLINIC USE ONLY: **INFLUENZA**

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