**INFLUENZA CONSENT FORM**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate “yes” or “no” for the following questions:**

( YES / NO ) Are you (or your child) currently sick with a fever?

( YES / NO ) Do you (or your child) have a severe allergy to eggs, latex, or an ingredient of the flu or

pneumococcal vaccine? If yes, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( YES / NO ) Have you (or your child) ever had Guillain Barre syndrome?

( YES / NO ) Is this you (or your child’s) first time getting the flu vaccine?

( YES / NO ) Have you (or your child) had a vaccine within the last 28 days?

If yes, which vaccine? Date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( YES / NO ) Have you ever had a pneumonia shot?

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( YES / NO ) Are you (or your child) a smoker?

( YES / NO ) Do you (or your child) have a chronic medical condition such as asthma, heart, or lung disease?

If yes, please indicate condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( YES / NO ) Are you (or your child) currently pregnant?

( YES / NO ) For children 2-4 years: has your child had asthma or wheezing episodes in the past year?

( YES / NO ) Have you (or your child) taken antiviral medication to prevent the flu within the last 48 hours?

( YES / NO ) Is your child or adolescent receiving long-term aspirin treatment?

( YES / NO ) Are you (or your child) currently receiving radiation, chemotherapy, or immunosuppressive therapy?

( YES / NO ) Do you (or your child) have close contact with anyone who has a severely weakened immune system?

I have read or had explained the Vaccine Information Statement about the **influenza** vaccination. I had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the **influenza** vaccination be given to me (or the person named above, for whom I am authorized to make this request). I authorize the release of any medical, or other information necessary to process a Medicare or other insurance claim or for public health purposes.

Signature of Recipient/Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_