Pinellas County Primary Care
AND HOSPITALISTS

2016-2017 Injectable Influenza Vaccination Consent

____ **Pediatric**	____ **Adult**	____ **Adult**
6 mo to 35 mo	36 mo (3 years) to Adult	65 yrs & up
FLUZONE QUADRIVALENT	**FLUZONE QUADRIVALENT**	**FLUZONE HD**
0.25 mL Prefilled Syringe (PFS)	0.5 mL Prefilled Syringe (PFS)	(High Dose)
Preservative-free	Preservative-free	0.5 mL Prefilled Syringe (PFS)
	42981-416.88	49281-399.88

Patient Name: ______________________________ **DOB:** ______________________
PLEASE PRINT MM/DD/YYYY

Please Read:

- If you have had recent chemotherapy, radiation therapy or steroids (except inhaled), these may decrease the effectiveness of the vaccine. However, flu vaccine is still encouraged.
- Because of the increased risk of influenza-related complications, the CDC and the ACIP recommend flu vaccination for women who will be pregnant or breast feeding during influenza season.
- For nursing mothers and/or women concerned with pregnancy/reproductive issues, we encourage you to discuss these issues with your physician.

YES	NO	CONTRAINDICATIONS
____	____	1. Are you allergic to eggs or egg products?
____	____	2. Are you allergic to Thimerosal (a preservative) other than lens sensitivity?
____	____	3. Have you ever had Guillain-Barre Syndrome within 6 weeks of taking a flu shot?
____	____	4. Have you ever had a serious reaction to a previous dose of influenza vaccine that required medical attention?

Physician Signature: ____
PHYSICIAN SIGNATURE IS NEEDED IS **ANY** QUESTION IS MARKED "YES"

I have been given a copy of the 2016-2017 Vaccine Information Statement (VIS) for Influenza. I have read this document and I understand the risk and benefits of the injectable influenza vaccine. I understand that I should report any changes of the above information before the vaccination. With this consent, I release my physician and sponsoring agency (Pinellas County Primary Care) from any and all liability associated with this vaccination or any adverse reactions which may occur as a result of this vaccination.

Patient/Guardian Signature: ________________________________ **Date:**______________

For Office Use ONLY:

Vaccine Manufacturer:______________________**Lot #:**______________ **Exp Date:**__________
NDC As Indicated Above
Site: ____ R/L Thigh (Vastus Lateralis)(PEDS only)____ Left Deltoid ____ Right Deltois Dose: __________mL

Team Member Signature: ____ Date: ________________