**Flu Vaccine Questionnaire/ Consent Form**

**Date:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Have you had the flu shot before? YES NO**
2. **Are you sick today? YES NO**
3. **Are you allergic to eggs? YES NO**
4. **Do you take asthma medication? YES NO**
5. **Is anyone in your household immune suppressed? YES NO**
6. **Do you have a chronic Medical Condition? YES NO**
7. **Is there a possibility that you may be pregnant? YES NO**

**I have read and received the vaccine information sheet for the Flu Vaccine and Understand the risk and side effects associated with the vaccine.**

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**

**Vaccine: FLUCELVAX**

**LOT# 252229**

**EXP: 05/2019**

**Injection Site:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  R / L  Deltoid**

**Clinician Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**