HALLSVILLE
MEDICAL CLINIC

Flu Vaccine Consent Form

Patient Information

- Full Name: _____
- Date of Birth: _____ Age: _____ Gender: _____
- Address: _____
- Phone: _____

Health Screening Questions

(Please check **Yes** or **No**)

1. Are you sick today? ☐ Yes ☐ No
2. Do you have allergies to egg, latex, or any component of the flu vaccine? ☐ Yes ☐ No
3. Have you ever had Guillain-Barré Syndrome (a severe paralytic illness)? ☐ Yes ☐ No
4. Have you ever had a severe reaction to a flu vaccine in the past? ☐ Yes ☐ No
5. Are you pregnant or breastfeeding? ☐ Yes ☐ No
6. Do you have any chronic medical conditions (e.g., asthma, diabetes, heart disease, immune disorder)? ☐ Yes ☐ No

If **Yes** to any of the above, please explain:

_____

_____

Consent for Influenza Vaccination

I have read (or had explained to me) information about the influenza vaccine. I have had a chance to ask questions and understand the benefits and risks of the vaccine. I request that the influenza vaccine be given to me (or the person named above for whom I am authorized to consent).

- Signature of Patient/Parent/Guardian: _____
- Printed Name: _____
- Date: _____

209 East Main Street Suite D Hallsville, Texas 75650 903-668-7462 fax 903-668-7400

For Clinic Use Only

- Vaccine: ☐ Quadrivalent Inactivated Influenza Vaccine (IIV4) ☐ Other: _____
- Dose: _____ mL Route: ☐ IM Site: ☐ Left Deltoid ☐ Right Deltoid
- Manufacturer: _____ Lot #: _____ Exp: _____
- Administered By (Name/Title): _____
- Date Given: _____