HOME CARE
INFLUENZA (FLU) VACCINE CONSENT FORM

Name _____ Age/DOB_____

Address_____

Phone_____ Physician Name/Location_____

1. Do you have or have you ever had an allergy to eggs or egg products? Yes No

2. Have you ever been diagnosed with Guillain Barre syndrome (a progressive paralysis that goes away after a period of time)? Yes No

3. Are you pregnant? Yes No

4. Do you have any allergies to medication or food? Yes No
   What?

I have read the information about the influenza (flu) vaccine and I feel that I should receive this immunization. I have had the opportunity to ask questions and understand the benefits and risks. I understand that, with all medical treatment, there is no guarantee that I will become immune from "the flu" or that I will not experience side effects from the vaccine.

I hereby give permission for Agency Name personnel to immunize me.

_____ _____
Participant Signature Date

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FLU VACCINE ADMINISTRATION

Manufacturer / Lot # _____

Site of Injection: ☐ Right Deltoid ☐ Left Deltoid

Signature of Nurse_____

Clinic Location: _____