

ETHS Health Center 2024-2025
INFLUENZA VACCINE
STAFF Consent and Administrative Record

Name: Last First M

Address

Birthdate Age

Have you had a bone marrow transplant in the past 6 months?
_____Yes _____No

Have you had an anaphylactic reaction to latex exposure?
_____Yes _____No

Have you ever had a severe (anaphylactic) reaction to a flu shot?
_____Yes _____No

Are you allergic to thimerosal (found in contact lens solution)?
_____Yes _____No

Do you have a history of Guillain-Barré Syndrome (GBS)?
_____Yes _____No

Do you currently have a fever, cough, congestion, or sore throat?
_____Yes _____No

Are you currently pregnant?
_____Yes _____No

"I have read or had read to me, the INFLUENZA VACCINE INFORMATION STATEMENT provided. I understand the information explained about the influenza vaccine. My questions about the vaccine were answered to my satisfaction. I understand the benefits and risks of this vaccine. I ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination."

X

Signature of patient

Date

FOR OFFICE/CLINIC USE ONLY

Sanofi			
LOT #	EXP DATE	MANUFACTURER	SITE OF INJECTION
ADMINISTERED BY		DATE ADMINISTERED	