Patient Consent Form for Seasonal Influenza Vaccine

Patient Name: _____

Patient Address: _____

Phone Number: (_____) _____-_____ Date Of Birth: _____

Employer name: _____

THE FOLLOWING INFORMATION IS REQUESTED BEFORE THE INFLUENZA VACCINE IS ADMINISTERED:

1. Do you have a cold? □YES □NO
2. Do you have a flu or flu like symptoms?(FEVER/ CHILLS/BODYACHES) □YES □NO
3. History of Guillain-Barre Syndrome (Nerve Disease) □YES □NO

*****Allergies to: *******

- Eggs: □YES □NO
- Eggs products: □YES □NO
- Any medications: □YES □NO
- Are you pregnant: □YES □NO

I_____ do hereby authorize MD Medical Clinics to administer the influenza vaccine. I understand that the influenza vaccine may not fully prevent influenza, but that it may lessen its complications. Influenza vaccine generally causes only mild side effects that occur at low frequency. Most commonly, the reactions may be a sore or tender arm at the injection site, or possibly fever or chills, headache or muscle aches for a period of 24 to 48 hours. Most people have little or no reaction, however, there is a possibility as with any vaccine or drug that an allergic or other serious reaction could occur.

I have read the above information and I understand the benefits and risk of influenza vaccine and I accept full responsibility should any adverse reactions occur.

_____ _____

Patient Signature Date

OFFICE STAFF USE ONLY

TEMP:_____ MALE:_____ FEMALE:_____ ____ RIGHT DELTOID ____LEFT DELTOID

Comments :_____

*Medical Assistant Signature :*_____ *Date:*_____