

Glastonbury & Manchester Influenza Immunization Consent Form 2016

Please Print:

| | | |
|------------------|-----------------|---------------------|
| First Name _____ | Last Name _____ | Date of Birth _____ |
|------------------|-----------------|---------------------|

| | |
|--|---|
| Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | Address: _____ (Street) |
| | _____ (Town) _____ (State) _____ (Zip Code) |
| | Phone: _____ |

| | |
|--|---|
| YES NO Are you sick with a fever? | YES NO Are you allergic to egg products or Thimerosal? |
| YES NO Have you ever had a serious reaction to a flu shot? | YES NO Are you pregnant or nursing? |
| YES NO Are you currently receiving radiation, chemotherapy, or immunosuppressive therapy? | YES NO Have you ever had Guillain Barre Syndrome? |
| | YES NO Are you taking a blood thinner? |
| | YES NO Are you allergic to latex? |

Upon receipt of the Vaccine Information Sheet (will be provided at the clinic)

I have read, or had explained to me, the information sheet about influenza and the influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I understand in rare instances a vasovagal reaction may occur as a result of vaccination. Knowing the benefit/risk of vaccination I agree to be vaccinated. I have read and agree to the Manchester Health Department privacy policy.

Signature _____ Date _____

For Clinic Use

Dose: 0.5 ml injectable Vaccine Manu: Flucelvax Quadrivalent Lot#: 185286 Exp: 04/2017

Site of IM Injection: Deltoid Left Right Date Administered: October 22, 2016

Signature & Title of Vaccine Administrator:
