2023-2024 School Clinic: Seasonal Influenza (flu) Vaccine Record and Consent

DO NOT RETURN THIS FORM IF YOU DO NOT GIVE CONSENT

PARENT LEGAL GUARDIAN INFORMATION (IF MINOR)

Parent/Legal Guardian Full Name _____

Relationship to Vaccine Recipient _____Day time phone number_____

VACCINE RECIPIENT INFORMATION

Last Name: _____First Name: _____M.I._____

DOB: _____/_____/_____AGE: _____ School: _____

Address: _____Town/City_____State: _____Zip: _____

Phone Number: _____

Screening for Vaccine Eligibility

*Please answer the questions below for **the person who is receiving the vaccine** to determine if there is any reason they should not get the influenza vaccine*. **If you answer "yes" to any of the questions, please contact your medical provider to discuss other ways to receive the vaccine.** If vaccine recipient is sick or unwell on the day of vaccination, they will not be vaccinated.	**YES**	**NO**
1. Have you ever had a severe allergic reaction (like anaphylaxis) to eggs or any component* of the influenza vaccine? **More information on vaccine ingredients (components) is available from the FDA at: https://www.fda.gov/vaccines-blood-biologics/vaccines/influenza-virus-vaccine-quadrivalent-types-and-types-b.		
2. Have you ever had a severe allergic reaction (like anaphylaxis) to a previous dose of any influenza vaccine?		
3. Have you ever had Guillain-Barre syndrome (GBS) (an autoimmune neurological condition that results in sudden muscle weakness) that developed within 6 weeks after receiving an influenza vaccine?		

CONSENT FOR 2023-2024 INFLUENZA VACCINATION: Please Read, Check Boxes and Sign

☐ By signing below, I am acknowledging that I have received and reviewed the information provided, I have had any questions satisfactorily answered, and I understand the risk and benefits of receiving the influenza vaccine. By signing below, I also confirm that the information entered on this form is accurate and I GIVE CONSENT for the person named above (Self or minor child) to be vaccinated with 1 influenza vaccine by Cottage Hospital Staff with or without a parent or guardian being physically present at the vaccine appointment.

☐ I have read the Influenza (Flu) Vaccine (Inactivated or Recombinant) Information Statement (VIS 8/6/2021)

☐ I consent to and authorize all medically necessary treatment in the rare event that the person named above (Self or minor child) has a reaction to the vaccine, including but not limited to itching, swelling, fainting, anaphylaxis, and other reactions.

Printed Name of Vaccine Recipient or Parent/Guardian: _____

Signature of Vaccine Recipient or Parent/Guardian: _____ Date: _____

FOR VACCINE ADMINISTRATOR USE ONLY

☐ I have verified consent form has been signed by vaccine recipient or parent/guardian

☐ I have asked the recipient if they are feeling sick or unwell today (if vaccine recipient is sick do NOT give vaccine)

☐ I have reviewed this form including the medical screening questions to identify potential vaccinate contraindications

☐ **I have verified the correct dosage**

Name: **Fluarix Quadrivalent Lot #**: _____ Expiration: 06/30/2024 Manufacturer: GlaxoSmithKline Dose: 0.5mL IM Deltoid: Left or Right NOTES:	Name: **Fluzone High Dose Quadrivalent** Lot #: _____ Expiration: 06/30/2024 Manufacturer: Sanofi Pasteur Dose: 0.7mL IM Deltoid: Left or Right NOTES:

ADMINISTERED BY:_____DATE:_____TIME:_____