**CONSENT FORM FOR INFLUENZA VACCINE**

**Title** [TITLE ]

**Name** [NAME]

**Last 4 SSN** [LAST 4 SSN]

Child’s Birthday[AGE]

Is your child 6 months of age or older? ☐ YES ☐ NO **(If “no,” your child may not receive the vaccine at this time.)**

Parent or Guardian’s Name: [NAME]

**Vaccine is for (check one):** ☐ Physician ☐ Contractor ☐ Employee ☐ Volunteer ☐ Family Member (Adult)

☐Family Member (Child) ☐ Other

# Company/Organization [NAME]

Has the person receiving the vaccine ever had a severe allergic (hypersensitivity) reaction to eggs, chickens, or chicken feathers?

☐ YES ☐ NO

Does the person receiving the vaccine have a history of Guillain-Barré syndrome or a persistent neurological illness?

☐ YES ☐ NO

Has the person received a live vaccine within the past 30 days (i.e. MMR, RotaTeq/Rotarix)? ☐ Yes\* ☐ No

Is the person receiving the vaccine pregnant?

☐ YES ☐ NO

Is the person receiving the vaccine allergic to Neomycin, Thimerosal (Preservative found in contact lens solution), any vaccine ingredient, or latex?

☐ YES ☐ NO

For children 6 mo-8 yrs: Have they received 2 or more doses of influenza vaccine since July 2015?

☐ YES ☐ NO

For children and adolescents aged 2-17 yrs: Is the child taking long-term aspirin or aspirin-containing therapy?

☐ YES ☐ NO

# Signature of person receiving vaccine OR Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_