

BETHLEHEM HEALTH BUREAU
 Seasonal Influenza Vaccination Consent Form

Name: _____ Date of Birth: _____ Sex: M ___ F ___

Address: _____ Telephone: _____

City: _____ State: _____ Zip Code: _____

Please circle YES or NO to the questions below:

- | | | |
|---|-----|----|
| 1. Does the patient have a severe allergy to eggs? | Yes | No |
| 2. Has the patient ever had a severe reaction to an influenza vaccine? | Yes | No |
| 3. Has the patient ever had Gullian-Barre syndrome? | Yes | No |
| 4. Does the patient have any other allergies? _____ | Yes | No |
| 5. Does the patient have asthma or recurrent or active wheezing? | Yes | No |
| 6. Is the patient under 18 years of age and currently receiving aspirin or aspirin containing therapy? | Yes | No |
| 7. Has the patient received either the MMR, Varicella, Yellow Fever or FluMist Vaccination in the past 30 days? Date: _____ | Yes | No |
| 8. Does the patient have any of the following long-term health problems?
(Please Circle) | Yes | No |
| Heart Disease Lung Disease Kidney Disease Metabolic Diseases (eg. Diabetes) | | |
| Other: _____ | | |
| 9. If applicable, is the patient pregnant or nursing? | Yes | No |
| 10. Does the patient have close contact with anyone who has a severely weakened immune system that must be in a protective environment (e.g. An individual who has had a bone marrow transplant)? | Yes | No |
| Please describe: _____ | | |

I have received and read the Centers for Disease Control and Prevention Vaccine Information Sheets dated 7/26/2011. I have no further questions at this time. I request and voluntarily consent that the seasonal influenza vaccine be given to person named above **of whom I am or am the parent or legal guardian.**

I want myself/my child to receive:

Flu injectable Flu mist(2 yrs-49 yrs old)

Signature: _____ Date: _____

OFFICE USE ONLY

Influenza Vaccine Given	Lot Number: _____	Injection Site: <u>L / R arm</u>
Dosage Volume: .25ml .5ml	Pre-filled	Intranasal
_____	_____	
Signature of vaccine administrator	Date	