Memorial Health Care Systems

Seward/Milford/Utica

Community Influenza Vaccine Consent

2024/25

Printed Name: _____Birth Date:_____ Age:_____

Street Address: _____Home Phone:_____

City:_____State:_____Zip:_____

Physician:_____

□ Attach copy of insurance card(s)

YES	NO	
□	□	1. Have you ever had Guillain-Barre Syndrome within 6 weeks of taking a flu shot?
□	□	2. Have you ever had a serious or life-threatening reaction to the influenza vaccine?
□	□	3. Do you have a fever or are you seriously ill today?

If you have checked "yes" to one of the above questions, you are **NOT** able to receive the flu shot at this time.

□	□	4. Do you experience symptoms other than hives after exposure to egg (such as angioedema, respiratory distress, lightheadedness, recurrent emesis)?

If you have checked "yes" to question 4, you may receive any licensed and recommended influenza vaccine that is otherwise appropriate. The vaccine should be administered in an inpatient or outpatient medical setting and you should be supervised for 30 minutes following the vaccination by a health care provider who is able to recognize and manage severe allergic reactions.

Special Health Conditions

If you have had recent chemotherapy, radiation therapy or steroids (except inhaled), these conditions may decrease the effectiveness of the vaccine. However, flu vaccination is still encouraged. You may wish to visit with your physician prior to receiving the vaccine. Flu vaccination is recommended for any woman who will be breastfeeding during the influenza season, or will be pregnant during the influenza season. Vaccination can occur in any trimester.

□ **YES, I have reviewed the influenza vaccine information statement and had my questions answered and I would like to have the influenza vaccine given to me.**

□ **I have had a severe allergic reaction to eggs and prefer that I receive the RIV4 (recombinant influenza vaccine) influenza vaccine.**

Recipient Signature: _____ **Date:** _____

Site: □ 0.5ml IM **Left** deltoid □ 0.5ml IM **Right** deltoid High **Dose** Only:

□ 0.5ml IM **Left** anterior thigh □ 0.5ml IM **Right** anterior thigh □ 0.5 ml IM **Left** deltoid

□ 0.5 ml IM **Right** Deltoid

Administered by: _____

Date: _____ (sticker)

Rev 8/28/24