INFLUENZA CONSENT

Patient Name	Birth Date

1. Do you have a fever today? .... ☐ Yes ☐ No
2. Are you feeling severely ill today? .... ☐ Yes ☐ No
   If yes, please explain: ____________________
3. Have you ever had a neurologic disorder or been diagnosed with the Guillain-Barre' Syndrome? .... ☐ Yes ☐ No
4. Do you have an allergy to chicken eggs, egg products, or latex? .... ☐ Yes ☐ No
   If yes, please explain: ____________________
5. Have you had a serious reaction to a flu shot before? .... ☐ Yes ☐ No
   If yes, please explain: ____________________

CONSENT FOR IMMUNIZATION

I hereby give my consent for CHI Health, its agents, and employees to administer the influenza vaccine. I understand that I may experience an adverse reaction from the vaccine. I understand that CHI Health and the employer sponsoring the flu vaccination today, if applicable, are not responsible for any reaction caused by this vaccine.

Please initial: ______ I acknowledge receipt of the Vaccination Information Sheet (VIS) dated 8/6/2021, and have had time to review it and have any of my questions answered.

Signature		Date
Signature of Parent/Legal Guardian if Patient is a Minor/Health Care Decision-Maker	Relationship to Patient	Date

FOR OFFICE USE ONLY

Influenza Vaccine	Deltoid Site	Given By (signature)	Date
	☐ Right ☐ Left		