NORTHERN MONTANA HEALTH CARE

CONSENT FOR INFLUENZA VACCINATION - COMMUNITY (INACTIVATED INFLUENZA VACCINE, INJECTABLE)

Name (Last, First, Middle Initial)		**Date of Birth**	**Phone**
Address	**City**	**State**	**Zip**
Insurance Plan			

Before agreeing to receive the vaccine, please take time to answer the following questions:

1.	Have you ever had a flu shot before?	YES	NO
2.	**ALLERGIES:** a. Do you have any ***SEVERE*** (life-threatening) allergies?	YES	NO
	b. Do you have a ***SEVERE EGG*** allergy?	YES Give Flublok	NO
	c. Do you have a ***SEVERE ALLERGY*** to any influenza vaccine component?	YES	NO
	d. Have you ever had a ***SEVERE*** reaction after a dose of influenza vaccine?	YES	NO
3.	Have you ever had ***GUILLIAN-BARRÉ SYNDROME*** (a severe paralytic illness, also called GBS)?	YES	NO
4.	Are you moderately or severely ill today?	YES	NO

Possible Vaccine Side-Effects and Adverse Reactions:

- Soreness at the injection site (10-65%)
- Fever, myalgia, and headache occur infrequently
- Immediate allergic reactions rarely occur.

I have read, or have had explained to me, the most recent Vaccine Information Statement (VIS) from the Centers for Disease Control (CDC) about influenza and influenza vaccine. I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the risks and benefits of influenza vaccine and request the vaccine to be given to me or the person named below for whom I am authorized to make this request.

_____ _____

Signature of person to receive vaccine or person authorized to make request Date

For Office Use Only

Administer 0.5 ml of injectable inactivated influenza vaccine intramuscularly (IM) (22-25g, 1-1½ ") in deltoid muscle

Injection Site: ☐ LEFT DELTOID ☐ RIGHT DELTOID

_____ _____/_____/_____

Nurse Signature Date

Affix Pharmacy Label Here

Manufacture: _____

Lot#: _____

Exp. Date: _____

VIS Date: _____

INF 0125 09/21

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