MY HEALTH ONSITE℠

FLU VACCINE CONSENT - 2019-2020

Documentation & Consent Form

Last Name:_____ **First Name:**_____ **Age:**_____ **DOB:**_____

Address:_____ **City:**_____

State:_____ **Zip code:**_____ **Phone Number** _____

INFLUENZA VACCINE SCREENING QUESTIONAIRE

Have you had a severe reaction to a flu shot in the past?	☐ **YES**	☐ **NO**
Do you have an active or history of a neurological disorder including Guillain-Barre Syndrome (GBS)?	☐ **YES**	☐ **NO**
Do you have any type of illness with fever, acute respiratory or other active infection or illness?	☐ **YES**	☐ **NO**
Are you pregnant? (Pregnant women should have a note from the OB/GYN) *and must be vaccinated in the health center*	☐ **YES**	☐ **NO**
For children aged 4 to 8 years old, please refer to the dosing schedule below- *Children must be vaccinated in the health center only*		

AGE	DOSE	SCHEDULE
4 Through 8 years of age	**1 or 2 doses, 0.5ml IM depending on vaccine history**	**If 2 doses are to be administered, administer 4 weeks apart**
9 years and older	**Administer 0.5ml IM as a single dose**	**Not applicable**
***It is important to check the brand of vaccine, since some brands are not approved for all age groups**		

PATIENTS WITH YES ANSWERS ABOVE – MUST POSTPONE VACCINATION UNTIL REQUIRED TIME HAS ELAPSED. (i.e. illness/fever resolved) OR FOLLOW UP WITH THEIR PROVIDER OR PRIMARY CARE PHYSICIAN TO RECEIVE MEDICAL CLEARANCE AND IN-OFFICE VACCINATION.

PATIENT AUTHORIZATION

I have been offered a copy of the Vaccine Information Statement(s) (VIS) for the influenza vaccine. I have read, had explained to me, and understand the information in the VIS(s). I ask that the influenza vaccine be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Florida Immunization Registry for myself or on behalf of the person named below:

Signature of Patient or Parent/Guardian:_____Date:_____

Name of Guardian (please print):_____

OFFICE USE ONLY

VACCINE	DOSE (volume administered)	EXTREMITY Left/Right	SITE Deltoid	ROUTE IM	VIS PUBLISH DATE	MANUFACTURER LOT #	EXP DATE
Flucelevax® Quadrivalent (90756) MDV	0.5ml			IM	8/7/2015		
Flucelevax® Quadrivalent (90674) Prefilled Syr	0.5ml			IM	8/7/2015		

VACCINE ADMINISTRATOR Signature:_____Title:_____

Upload this signed consent to the patient's EHR

Vaccine Administration Date:_____VIS Form given on same date as vaccine administration? YES NO

Physician Standing order for Influenza administration on file for the 2019–2020 season.