MY HEALTH ONSITE℠
Proactive. Engaged. Personalized.

FLU VACCINE CONSENT

DOCUMENTATION & CONSENT FORM 2023-2024

INFORMATION ABOUT YOU

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ____/____/____ (mm / dd / yyyy) Phone: _____ (Home) _____ (Cell)

Address: _____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

INFLUENZA VACCINE SCREENING QUESTIONAIRE

Please check YES or NO for each question.	Yes	No
1. Have you had a severe reaction to a flu shot in the past?		
2. Have you had a severe allergy to eggs or egg products? (Fluad® only)		
3. Do you have an active or history of a neurological disorder including Guillain-Barre Syndrome (GBS)?		
4. Do you have any type of illness with fever, acute respiratory or other active infection or illness?		
5. Are you pregnant? **Patients may receive the vaccine at the health center per the CDC		
6. Do you have an allergy to thiomersal (contact lens solution)? (Only for multidose vials)		
7. Do you have an allergy to Kanamycin and/or Neomycin? (Fluad® only)		
8. Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days? If so, your dose will be postponed until the quarantine period has ended.		

For children aged 6 to 8 years old, please refer to the dosing schedule below- Children must be vaccinated in the health center only.

AGE	DOSE	SCHEDULE
6 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 aged 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	08/06/2021		
Flucelevax® Quadrivalent (90674) Prefilled Syr	0.5ml			IM	08/06/2021		
Fluad Quadrivalent - Age 65 Years and Older (90694) Prefilled Syr	0.5ml			IM	08/06/2021		

Vaccine Administrator Signature: _____ **Date:** _____

Upload this signed consent to the patient's EMR

Vaccine Administration Date: _____ **VIS Form given on same date as vaccine administration?** **YES** **NO**

Provider Standing order for Influenza administration on file for the 2023-2024 season.