



# FLU VACCINE CONSENT - 2020-2021

## Documentation & Consent Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Phone Number \_\_\_\_\_

### INFLUENZA VACCINE SCREENING QUESTIONNAIRE

Have you had a severe reaction to a flu shot in the past?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you had a severe allergy to eggs or egg products?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have an active or history of a neurological disorder including Guillain-Barre Syndrome (GBS)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any type of illness with fever, acute respiratory or other active infection or illness?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you pregnant? <b>** Patients may receive the vaccine at the health center per the CDC</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>For children aged 4 to 8 years old, please refer to the dosing schedule below- Children must be vaccinated in the health center only</b>		

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
<b>***It is important to check the brand of vaccine, since some brands are not approved for all age groups</b>		

**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 (90674) Prefilled Syr	0.5ml			IM	8/15/2019		
Fluarix® Quadrivalent (90686) Prefilled Syr	0.5ml			IM	8/15/2019		
Afluria® Quadrivalent (90686) Prefilled Syr	0.5ml			IM	8/15/2019		

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 2020-2021 season.