

2022-2023 Consent for Influenza Vaccination

Name:			Date of Birth://	Ag	e:
Address:					
City:					
Legal Sex: OF O M O Nonbinary O					
Phone : (Home/Mol	bile) E	mail:			
COVID-19 Screening		Influenza Screening			
Have you had a fever, cough, shortness of breath, loss of taste or smell or any other cold/flu symptoms in the last 24 hours?	Yes	No	Have you received the flu vaccine before?	Yes	•
Have you or a household member been tested, diagnosed, or awaiting COVID-19 test results in the last 14 days?	Yes	No	Have you had a severe reaction to the flu vaccine in the past?	Yes	•
			Do you have a serious allergy to chicken eggs? If yes, please discuss vaccination options with physician or allergist.	Yes	•
			Do you have a history of Guillian-Barre Syndrome (GBS)?	Yes	ı
			Are you currently sick with a fever?	Yes	ı
Participant/Parental Informed C	onse	ent S	Signature		
By signing, I have received and agreed to the following: Received and read the vaccine information sheet (da	ated 8/6/2	1) rega	ording benefits and risks of receiving the Influenza	ı vaccine	÷
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