PATIENT NAME: _____ **Birth Date:** _____
(First Name) *(Last Name)*

PLEASE FILL OUT THE QUESTIONS BELOW ONLY
FOR THE VACCINE(S) YOU WOULD LIKE TO RECEIVE TODAY.

Influenza Vaccine Consent Form

Does/Has the person named above	YES	NO
ever had a serious allergic reaction or other problem after getting influenza vaccine?		
ever had Guillian-Barre Syndrome?		
have a fever (100.4° +) or severe illness today?		

If you answered YES to any of the above, you may not be able to receive the flu vaccine today.

COVID-19 Vaccine Consent Form

Does/Has the person named above	YES	NO
Been diagnosed with COVID-19 in the last 10 days?		
Received monoclonal antibodies in the last 90 days?		
Have allergy to previous COVID-19 vaccine?		
Has history of anaphylaxis to a vaccine or other triggers?		
Ever received a COVID vaccine? If YES, when: _____ NO: _____		

If you answered YES to any of the above, you may not be able to receive the COVID vaccine today.

I have been offered a copy and have read or have had explained to me the information in this pamphlet (Vaccine Information Statement/VIS) about the disease and vaccine(s) indicated below. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the indicated vaccine(s) being given to me.

If either vaccine is not covered by your health plan, you will be responsible for payment.

PLEASE SIGN:

Signature of person to receive vaccine or the person authorized to make the request (e.g., authorized representative or legal guardian):

X_____ **Date**_____

Relationship: _____

OFFICE USE ONLY:

FLU VACCINE

Performed By:_____ **LOT STICKER:** _____

Site: L Deltoid R Deltoid L Thigh R Thigh **Dose:** 0.5ml

COVID VACCINE

Performed By:_____ **LOT STICKER:** _____

Site: L Deltoid R Deltoid L Thigh R Thigh **Dose:** 0.25ml 0.5ml