West Caldwell Health Council, Inc.

Collettsville Medical Center
4329 Collettsville Rd.
PO Drawer 9
Collettsville, NC 28611

Happy Valley Medical Center
1345 Highway 268
PO Box 319
Patterson, NC 28661

Influenza Vaccine Consent Form

Patient Name: _____ Date of Birth: _____

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Please answer the following questions about the person to be vaccinated:	**YES**	**NO**	**DON'T KNOW**
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Is the person to be vaccinated allergic to eggs?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barre syndrome?	☐	☐	☐

Notify the HCP if any questions above are answered "yes"

STATEMENT OF UNDERSTANDING:
I have read the information provided to me on the Vaccine Information Statement (VIS).
I understand the benefits/risks of this immunization and have had the opportunity to ask questions.
I have answered the questions on the screening questionnaire truthfully.

_____ _____
Patient/Guardian Signature **Date**

FOR OFFICE USE ONLY

Influenza Vaccine afluria® Quadrivalent: Seqirus™

Check which applies: ☐ Vaccine Lot/Exp. Date: _____/_____ **(Prefilled syringe)**

☐ Vaccine Lot/Exp. Date: _____/_____ **(Multi-dose vial)**

Injection Site (check): ☐ Right Deltoid or ☐ Left Deltoid Dosage: 0.5 ml

Stock (check one): ☐ Private or ☐ State Diagnosis Code: Z23

Patient reaction/comments: _____

_____

Administered by: _____ Date: _____

☐ **IN EMR** ☐ **IN NCIR**