

# 2023-2024 Influenza Vaccination Consent Form



Full Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_ Insurance: \_\_\_\_\_

<b>Flu vaccination screening questions:</b>	1. Are you sick today? (minor illness is not a contraindication to vaccination)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	2. Do you have a life-threatening allergy to a vaccine component?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	3. Have you had a life-threatening reaction to an influenza vaccine in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	4. Have you ever had Guillain-Barré syndrome w/in 6 weeks of flu vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>LAIV eligibility: ONLY COMPLETE THIS SECTION IF FLUMIST DESIRED. A "YES" ANSWER IN THIS SECTION MEANS THAT YOU SHOULD NOT HAVE LIVE INFLUENZA VACCINATION SUCH AS FLUMIST. (YOU CAN STILL HAVE THE FLU SHOT.)</b>	1. Are you 50 years of age or older?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	2. Do you have a chronic health condition that includes any of the following: <i>Heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes); anemia or other blood disorder; or a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	3. Are you pregnant or planning to become pregnant in the next month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	4. Do you have close contact with patients currently hospitalized for bone marrow transplants?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	5. Are you taking daily antiviral medications or, if less than 18, daily aspirin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	6. Have you received MMR, Varicella, MMRV, or yellow fever vaccines in the last 4 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please note: The flu vaccination you receive today will be recorded in MIIC (the Minnesota Immunization Information Connection, the statewide immunization registry). Information in MIIC is confidential and will only be shared with organizations or persons authorized by law to receive it. If you do not want to participate in the registry, please call 1-800-657-3970. Vaccination will also be recorded in the GRHS Medical Record. If you have had recent chemotherapy, radiation therapy, or steroids (except inhaled), the vaccine effectiveness may be decreased. However, influenza vaccination is still encouraged. Flu vaccination is also strongly encouraged for any woman who is/will be pregnant or breastfeeding during influenza season. Vaccination can be safely given during any trimester.

**YES, I consent to have the influenza vaccine**

**Signature of recipient or legal guardian** \_\_\_\_\_

Date administered/VIS given: ____/____/____		Date of VIS: 08/06/2021
<b>Lot #:</b> Fluzone: _____ Fluzone HIGH DOSE: _____ FluBlok (egg free): _____ FluMist: _____	<b>Mfg:</b> SANOFI PMC  MED IMMUN	<b>CPT code (circle):</b> 90686 = IIV4 Fluzone p-free 90662 = IIV Fluzone high dose (≥65 yrs) 90674 = IIV4 Cell Culture p-free (Flublok Egg free) 90672 = Live intranasal FluMist  <b>Exp date</b> _____ 06/30/2024 (Fluzone) _____ 06/30/2024 (FluBlok) _____ 12/14/2023 (FluMist)
<b>Route:</b> IM Nasal	<b>IM Site:</b> R delt _____ L delt _____	<b>Name and title of vaccine administrator:</b> _____