# 2024-2025 Influenza Vaccination Consent Form

GLACIAL RIDGE HEALTH SYSTEM

Full Name: _____ _____ Date of birth:_____

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| **Flu vaccination screening questions:** | 1. Are you sick today? (minor illness is not a contraindication to vaccination) | ☐ Yes | ☐ No |
| | 2. Do you have a life-threatening allergy to a vaccine component? | ☐ Yes | ☐ No |
| | 3. Have you had a life-threatening reaction to an influenza vaccine in the past? | ☐ Yes | ☐ No |
| | 4. Have you ever had Guillain-Barré syndrome w/in 6 weeks of flu vaccine? | ☐ Yes | ☐ No |
| **LAIV eligibility: ONLY COMPLETE THIS SECTION IF <u>FLUMIST</u> DESIRED.** **A "YES" ANSWER IN THIS SECTION MEANS THAT YOU SHOULD <u>NOT</u> HAVE LIVE INFLUENZA VACCINATION SUCH AS FLUMIST. (YOU CAN STILL HAVE THE FLU SHOT.)** | 1. Are you 50 years of age or older? | ☐ Yes | ☐ No |
| | 2. Do you have a chronic health condition that includes any of the following: *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?* | ☐ Yes | ☐ No |
| | 3. Are you pregnant or planning to become pregnant in the next month? | ☐ Yes | ☐ No |
| | 4. Do you have close contact with patients currently hospitalized for bone marrow transplants? | ☐ Yes | ☐ No |
| | 5. Are you taking daily antiviral medications or, if less than 18, daily aspirin? | ☐ Yes | ☐ No |
| | 6. Have you had MMR, Varicella, MMRV, or yellow fever vaccine in the last 4 weeks? | ☐ Yes | ☐ 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. NOTE: Flublok is approved only for adults.**
**Patient/guardian *Signature*_____**

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| **Date** administered/VIS given: ____/____/_____ | | | Date of VIS: 08/06/2021 |
| **Lot #**:<br>Fluzone<br>U8486BA UT8475KA<br>_____<br>Fluzone HIGH DOSE:<br>UT8437BA U8507DA<br>_____<br>FluMist:<br>WF2584B<br>_____<br>Flublok (egg-free):<br>U8447AA | Mfg:<br>SANOFI PMC<br><br>MED<br>IMMUN | CPT code (circle):<br><br>Exp date | 90656 = IIV3 Fluzone trivalent p-free **0.5ml**<br>90662 = IIV3 Fluzone trivalent high dose **0.5 ml** (≥65 yrs)<br>90672 = Live intranasal FluMist<br>90673 = RIV3 Flublok (Egg-free) trivalent **0.5 ml**<br>_____ 06/30/2025 (Fluzone)<br>_____ 12/19/2024 (FluMist)<br>_____ 5/31/2025 (Flublok) |
| **Route**:<br>IM _____<br>Nasal_____ | **IM Site**:<br>R delt _____<br>L delt _____ | **Name and title of vaccine administrator:**<br>_____ | |