Influenza Vaccination
Assessment, Release and Consent Form

Name:_________________________________Gender: M___ F____ Date:_____________

Address:______________________________________ City:________________ State:_____

Zip:___________ Birth Date:___________ Age:______ Phone #:________________

Physician:___________________________________

- Have you received an influenza vaccination this year? Yes No
- Have you ever had a severe reaction to a flu shot or eggs? Yes No
- Have you ever had Guillain-Barre? Yes No
- Are you currently running a fever or feeling ill? Yes No

I have read the information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. I authorize billing of this vaccination to my health insurance. I also acknowledge that I have had an opportunity to receive a copy of the "Notice of Privacy Practices" dated August 2013 from the Health Department.

Signature:____

Please return to Health Dept. Employee.

For Nurses Use Only

SITE: RD/LD ❍Lot#:

Expiration Date:
Manufacturer: Administered By:_________________________

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