Flu Vaccination Consent Form

It is recommended that anyone receiving a vaccine remain for at least 15 minutes after to monitor for allergic reactions.

Patient's Name: Date of Birth:

1. Have you had the flu shot before?	**YES**	**NO**
2. Are you allergic to thimerosal, eggs, or egg products?	**YES**	**NO**
3. Have you ever had an allergic reaction to flu or other vaccine?	**YES**	**NO**
4. Is there a chance you are pregnant?	**YES**	**NO**
5. Are you currently sick (does not include minor illnesses)?	**YES**	**NO**
6. Do you have a history of Guillain-Barre Syndrome?	**YES**	**NO**

I have answered the above questions to the best of my knowledge. I have received and read the information sheets for the flu vaccination I wish to receive and have had the opportunity to ask questions. I agree to remain in the clinic for at least 15 minutes after vaccination if it is my first time being vaccinated. I hereby consent to the administration of the flu vaccine.

Signature: _____ Date: _____