FightFlu TN Influenza Vaccine

PLEASE PRINT

Patient Last Name:	First Name:	MI:
Sex: ❑ M ❑ F	DOB: / /	Current Age:
Race: ❑Asian ❑Black ❑Native American ❑Pacific Islander ❑White ❑Other:	Ethnicity: Hispanic ❑Yes ❑No	
Address:	City: State:	Zip:
Phone: ( )		

The following questions will help determine if there is any reason you should not receive an influenza immunization injection. **Answering "yes" to any question does not prevent you from being vaccinated.**
It means additional questions will be asked.
If a question is not clear, please ask a healthcare provider to explain.

1.	Has the person to be vaccinated ever received a flu vaccine?	❑ Yes	❑ No
2.	If the person to be vaccinated is a child age 6mo – 8yrs, have they received at least 2 seasonal influenza vaccine doses prior to last July 1st?	❑ Yes	❑ No
3.	Is the person to be vaccinated sick today?	❑ Yes	❑ No
4.	Does the person to be vaccinated have an allergy to a component of the vaccine?	❑ Yes	❑ No
	List all allergies to food/drugs:	❑ Yes	❑ No
5.	Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	❑ Yes	❑ No
6.	Has the person to be vaccinated ever had Guillain-Barre´ syndrome?	❑ Yes	❑ No

Request for Administration of Influenza Vaccine for the above named recipient: I acknowledge that I have received the Vaccine Information Statement and the Hamilton County Health Department's Notice of Privacy Practices. I have been advised to wait 20 minutes in the observation area after receiving the vaccine. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I hereby release Hamilton County Health Department, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____
PARENT/LEGAL GUARDIAN NAME: _____

This consent is valid for 12 months from date signed

AREA FOR OFFICIAL USE ONLY

Program Code: ☐ **AH** ☐ **IM** ☐ **CH** POD/DVC Location:_____

Immunization: Dose: **0.5 mL**

☐ **Fluzone Quad MDV**	**Lot No: UJ705AB**	**Exp Date: 06/30/2022**	**VIS Date: 08/06/2021**
☐ **Flucelvax Quad PFS**	**Lot No: 308453**	**Exp Date: 06/30/2022**	**VIS Date: 08/06/2021**
☐ **Fluzone High Dose PFS**	**Lot No: UJ748AA**	**Exp Date: 06/30/2022**	**VIS Date: 08/06/2021**

Site Administered: ☐ **Right Deltoid** ☐ **Left Deltoid** ☐ **Right Thigh** ☐ **Left Thigh**

Date Given:_____ Provider Name:_____

☐Vaccine **NOT** given secondary to contraindication:_____