

# Influenza Vaccine Consent Form

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

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- Do you have allergies to eggs or egg protein?  Yes  No
- Have you ever had a severe allergic reaction to a flu shot?  Yes  No
- Are you **under** 18 years of age?  Yes  No
- Have you ever had Guillain-Barre' Syndrome?  Yes  No
- Do you currently have a temperature of 100.4 or greater, or generally not feeling well (You may want to postpone)?  Yes  No
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I have read the above information about influenza, the vaccine, and the possible side effects. I have had an opportunity to ask questions regarding recommendations and understand the benefits and risks of flu vaccination as described. VIS – Inactivated Influenza vaccine 08/15/2019 provided. I request that the vaccination be given to me. By signing below, I am also giving consent for Quick Care to take a picture of my photo ID and insurance card to be used for billing purposes only.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

## Office Use Only:

.5cc Influenza Vaccine Administered Date:  9/15/20 Time: \_\_\_\_\_ Location: QC Drive Thru Clinic  
 9/17/20  QCB  QCF

By: \_\_\_\_\_  R  L Deltoid  Fluzone Quad  
Signature  Fluzone High Dose