**ADULT FLU VACCINE CONSENT FORM**

**(18 YEARS AND OLDER)**

Your child’s Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient I.D. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize consent to receive:

 FULL NAME (PRINT) DOB

 \_\_\_\_ Flu Mist – Ages 2yr -49yr only, cannot have had MMR, VAR or MMRV within a month of getting Flu Mist.

**FOR CLINICAL USE ONLY**

Lot Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Administered By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Flu Shot

|  |  |  |
| --- | --- | --- |
| **The following questions will help us determine your eligibility to be vaccinated today. Please answer all questions.** | **Yes** | **No** |
| * Is your insurance an HMO? **All HMO patients MUST receive shots at their PRIMARY CARE office ONLY)**
 |  |  |
| * Do you have allergies to medications? (Examples: Gelatin, Gentamicin, Polymyxin, Neomycin) **If yes, please list allergies:**
 |  |  |
| * Have you ever had a serious reaction to an influenza vaccine?
 |  |  |
| * Have you had a seizure disorder for which you are on a seizure medication(s), a brain disorder, Guillain-Barre Syndrome (a condition that causes paralysis) or other nervous system problems?
 |  |  |
| * Are you taking any anticoagulant therapy medications, including aspirin?
 |  |  |
| * Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves or blood?
 |  |  |
| * Do you have a weak immune system (for example, from HIV, cancer or medications such as steroids or those used to treat cancer?
 |  |  |
| * Are you pregnant or nursing?
 |  |  |
| * Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?
 |  |  |

***\*\*\* I UNDERSTAND THAT IF MY INSURANCE DOES NOT COVER THE FLU SHOT OR IF I AM UNABLE TO PROVIDE MY INSURANCE CARD, I WILL BE RESPONSIBLE FOR THE COST OF THE FLU SHOT \*\*\****

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SIGNATURE DATE

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***Patients Only:***

\_\_\_ **I decline** the Flu Vaccination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SIGNATURE DATE

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_