PATIENT NAME: _____ **Birth Date:** _____

(First Name) *(Last Name)*

PLEASE FILL OUT THE QUESTIONS BELOW <u>ONLY</u> FOR THE VACCINE(S) YOU WOULD LIKE TO RECEIVE TODAY.

Influenza Vaccine Consent Form

Does/Has the person named above	YES	NO
ever had a serious allergic reaction or other problem after getting influenza vaccine?		
ever had Guillian-Barre Syndrome?		
have a fever (100.4° +) or severe illness today?		

If you answered YES to any of the above, you may not be able to receive the flu vaccine today.

COVID-19 Vaccine Consent Form

Does/Has the person named above	YES	NO
Been diagnosed with COVID-19 in the last 10 days?		
Received monoclonal antibodies in the last 90 days?		
Have allergy to previous COVID-19 vaccine?		
Has history of anaphylaxis to a vaccine or other triggers?		
Ever received a COVID vaccine? If YES, when: _____ NO: _____		

If you answered YES to any of the above, you may not be able to receive the COVID vaccine today.

I have been offered a copy and have read or have had explained to me the information in this pamphlet (Vaccine Information Statement/VIS) about the disease and vaccine(s) indicated below. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the indicated vaccine(s) being given to me.

PLEASE SIGN:

Signature of person to receive vaccine or the person authorized to make the request (e.g., authorized representative or legal guardian):

X_____ **Date**_____

Relationship: _____

<u>OFFICE USE ONLY:</u>

FLU VACCINE

Performed By:_____ **LOT STICKER:** _____

Site: L Deltoid R Deltoid L Thigh R Thigh **Dose:** 0.5ml

COVID VACCINE

Performed By:_____ **LOT STICKER:** _____

Site: L Deltoid R Deltoid L Thigh R Thigh **Dose:** 0.25ml 0.5ml