CONSIGLIO
WELLNESS CENTER

DISTRICT_____

CONSENT FOR SEASONAL INFLUENZA VACCINE

I have been given a copy of the Vaccine Information Statement (VIS) and have had the opportunity to review it, as well as ask questions regarding the vaccine. My questions were satisfactorily answered. I believe I understand the benefits and the risks of the influenza vaccine. I understand this consent form will become part of my medical record at the Consiglio Wellness Center (CWC) and will be kept in accordance with the CWC Privacy Policies. I am aware that the CWC Privacy Policies are available for my review at the CWC or may be found at www.ConsiglioWellnessCenter.com.

Patient Information (Person to Receive Vaccine) *Please Print*

_____

Last First MI Birth Date Age

_____

Street Address

_____ **M** ☐ **F** ☐

City State Zip Telephone # Sex

Please answer the following questions as it pertains to the person receiving the vaccine:

Fever of 100.0 or greater in the past 72 hours? Yes ☐ **No** ☐

Allergy to eggs or neomycin? Yes ☐ **No** ☐

Have you received any other vaccine in the past 2 weeks? If yes, what vaccine and when? _____

Allergy to latex, or a previous dose of flu vaccine? Yes ☐ **No** ☐

Epilepsy or other nervous system condition? Yes ☐ **No** ☐

History of Guillain-Barre syndrome? Yes ☐ **No** ☐

History of severe swelling or severe pain following a previous dose of flu vaccine? Yes ☐ **No** ☐

If answered yes to any questions, please explain: _____

Is the person receiving the vaccine pregnant? Yes ☐ **No** ☐

Signature of Patient/guardian: _____ **Date:** _____/_____/_____

_____

*****For Office Use Only****

Date vaccinated: _____/_____/_____ Route: Intramuscular Injection Site: (R) or (L) Deltoid

Signature/Title: _____ Place label here for individual vial:

Consiglio Wellness Center
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Blue Springs, MO 64015
816-874-3379