**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](http://www.ConsiglioWellnessCenter.com).

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

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**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: