CONSIGLIO
WELLNESS CENTER

DISTRICT_____

CONSENT FOR INFLUENZA VACCINE

PEDIATRIC CONSENT – AGES 6 months and up

I have been given a copy of the Vaccine Information Statement (VIS) and have had the opportunity to review it. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and the risks of the influenza vaccine and request this vaccine be given to me or the person named below for whom I am authorized to make this request. I understand this consent form with become part of my medical record at the Consiglio Wellness Center (CWC) and will be kept in accordance with the CWC Privacy Policies. I understand that the CWC Privacy Policy is available for my review at the CWC or at www.consigliowellnesscenter.com.

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

_____

Last First MI Birth Date Age

_____

Address

_____

City State Zip Telephone # Sex: **M**☐ **F**☐

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 the flu vaccine? ☐**Yes** ☐ **No**

If answered yes to any questions, please explain: _____

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

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

****FOR OFFICE USE ONLY****

Date vaccinated: _____/_____/_____ 2nd vaccine due Yes ☐ No ☐ Date 2nd vaccine due _____/_____/_____

Route: Intramuscular Injection Site: Deltoid (R) or (L) Thigh (R) or (L)

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

Consiglio Wellness Center
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