2022-2023 INFLUENZA VACCINE CONSENT

INFORMATION ABOUT THE PERSON TO RECEIVE THE VACCINE

_____ _____

Name: Last, First, MI Date of Birth

EMPLOYED BY: CHECK ONE BELOW

_____

Employee ID

PH BROOKVILLE	**PH TYRONE**
PH CLEARFIELD	**PHCNI**
PH CONNELLSVILLE	**HELPMATES**
PHH CORPORATE	**PH PHYSICIAN NETWORK**
PH DUBOIS	**JEFFERSON MANOR**
PH ELK	**WRC/MCKINNLEY HEALTH CENTER**
PH HUNTINGDON	**PINECREST MANOR**
PH MON VALLEY	

_____

Telephone Number

	YES	NO
Are you allergic to chicken or eggs?	□	□
Have you ever been paralyzed with Guillain-Barre Syndrome?	□	□
Are you sick today (anything more serious than a "cold")?	□	□
Do you have a fever?	□	□
Have you ever had an allergic reaction to the influenza vaccine?	□	□
Do you have a latex allergy?	□	□
Are you allergic to thimerosal (a mercury-based preservative)?	□	□
Are you taking any antiviral medication?	□	□
Have you received any other vaccinations in the past four weeks?	□	□
Are you pregnant, or do you think you may be pregnant?	□	□
Do you have a long-term health problem such as heart disease, lung disease, kidney disease, metabolic disease such as diabetes, asthma, neurologic or neuromuscular disease, or anemia or another blood disorder?	□	□
Do you have a weakened immune system because of HIV/AIDS or any other disease that attacks the immune system, long term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	□	□
Do you live with, or expect to have contact with, a person whose immune system is severely compromised and must be in protective isolation (such as an isolation room of a bone marrow transplant unit)?	□	□

I have received and read a copy of the CDC Vaccine Information Statement (VIS) dated 08-16-2021. I believe I understand this information, and my questions have been answered to my satisfaction. I understand the benefits and risks of the influenza vaccine and request the vaccine be given to me.

□ I CONSENT to informing my PCP Dr. _____ that I have received the flu vaccine.

X _____ Date _____

Signature of person receiving vaccine

FOR CLINIC/OFFICE USE

_____ _____ _____

Vaccine Manufacturer Lot Number Expiration Date

Injection Site: IM ____L Deltoid ____ R Deltoid Quadrivalent ____ High Dose _____ FLU BLOK _____

_____ _____

Clinician Date