I have been given the U.S. Department of Health & Human Services' fact sheet titled *Influenza Vaccine What You Need to Know (issuance date 8/15/2019)*. I have read the sheet and have had my questions answered to my satisfaction regarding the Influenza Vaccine, including risks, benefits, and possible adverse reactions or complications associated with the vaccine. I, hereby, consent to and authorize ____________ Slicer Health Clinic __________________ facility through its designated agents or representatives, to administer to __________________________________ *(print full name)*, the Influenza Vaccine. I acknowledge that no guarantee or assurance has been made to me regarding the vaccine. The facility, by making this vaccine available to me, provides no warranty to me with respect to the vaccine.

☐ Yes ☐ No Have you ever had an allergic reaction to eggs, gelatin, neomycin, streptomycin, or a previous influenza vaccination?

☐ Yes ☐ No Do you have a history of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination?

☐ Yes ☐ No Are you a minor? (less than 18 years of age)

**If yes to any of the above, do not administer vaccine without physician's approval.*

Injection Site ______________________

Given By Date Time ______________________

Expiration Date ______________________

Manufacturer/Lot Number ______________________

Issuance/Publication Date of Vaccine Information Sheet (VIS) 8/15/2019

Patient's Signature or Legal Representative			Date/Time
Relationship to Patient		Interpreter, if Utilized	Date/Time
Witness Signature	Date/Time	If Telephone Consent, Second Witness Signature	Date/Time

Influenza Vaccination Consent
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ORIGINAL – Medical Record COPY – Recipient

NAME:______________________

LPN Pediatric Care

DOB:__________