COMMUNITY HEALTH ALLIANCE

Vaccine Informed Consent (Flu)

Patient Information	
First Name: _____	Last Name: _____
Date of Birth: _____	Primary Care Provider: _____
Address: _____	
Home Phone: _____	Cell Phone: _____

Insurance Information	
Insurance Name: _____	Insurance ID Number: _____
	Insurance Group Number: _____

I, the undersigned, have read or had explained to me the vaccination information sheet (VIS). I understand the risks and benefits associated with the vaccine(s) and have had my questions answered to my satisfaction. I voluntarily request that the vaccine be given to me or for the aforementioned person for whom I am authorized to make this request.

☐ I authorize the vaccine to be administered by a trained student pharmacist.

Signature: _____ Date: _____

Print name of parent, guardian or caregiver: _____

Screening Questionnaire			
	Yes	**No**	**Unknown**
Are you currently ill or do you have a fever?	☐	☐	☐
Have you ever received the flu vaccine before?	☐	☐	☐
Have you ever had a serious reaction to a vaccine before?	☐	☐	☐
Do you have an allergy to eggs or to any component of a vaccine?	☐	☐	☐
Have you received any vaccines in the last 4 weeks?	☐	☐	☐
For women: Are you currently pregnant?	☐	☐	☐

Lot	Expiration	Manufacturer	Dose	Site (RD, LD, RT, LT)

Signature of Pharmacist/Provider: _____ Date: _____

☐ Entered into WebIZ

Funding: ☐ 317 ☐ Private

Last updated: April 2020