FAITH COMMUNITY HEALTH SYSTEM

Patient's Name:_____ Address:_____ Phone #:_____ DOB:_____ Manufacture: **Sanofi Pasteur** **INSURANCE: Attach a copy of your card** or $20.00	

Influenza Vaccine Consent: **Check yes or no**

1. Are you pregnant or is there a chance that you could become pregnant during the next month.
   Yes _____ No_____
2. I **do not** currently have an acute respiratory infection or any other known infection or fever at this time.
   Yes _____ No_____
3. I understand that the vaccine is **not 100% effective** in preventing influenza.
   Yes_____ No_____
4. I understand the common side effects from the influenza vaccine may occur at injection site: pain, redness, swelling, bruising and hardness, Muscles aches, Fatigue, and headache.
   Yes _____ No_____
5. Have you or your child had Guillain-Barre syndrome (Severe muscle weakness) after getting a flu vaccine?
   Yes _____ No_____
6. Have you or your child had problems with your immune system as the immune response may be diminished?
   Yes_____ No_____
7. I have read and understand the risks and benefits of receiving the Influenza vaccine from the Vaccine Information Sheet. REVP. 08-06-2021.
   Yes _____ No_____

The following **should not receive** the Fluzone Quadrivalent vaccine if you:

- Ever had a severe allergic reaction (anaphylactic) to eggs or egg products
- Ever had a severe allergic reaction (anaphylactic) after getting any flu vaccine
- **Quadrivalent is not for anyone under 06 months of age**

The undersigned has requested to be administered the influenza vaccine injection by Faith Community Health System representative. In making this request, the undersigned recognizes that he/she is receiving the vaccine on a voluntary basis; thus releasing Faith Community Health System, its employees, representatives, and agents from any liability for giving me the influenza vaccination. I accept responsibility for seeking medical attention for any problems associated with my receiving the vaccine.

Signature:_____ **Date:**_____

You are receiving **the AFLURIA QUADRIVALENT (Influenza Vaccine)** which contains 4 killed flu virus strands :
A/California/ (H1N1) A/Victoria/ H3N2 B-Brisbane/Victoria Lineage, B-Florida/Yamagata Lineage

LOT#	EXPIRATION DATE	DOSE	SITE AND ROUTE	GIVEN BY:

UT7325KA	06/30/2022	0.5ML	RT. OR LEFT Deltoid IM OR Infant thigh muscle RT or LFT.	

Consent for Immunization of a Minor:

I, (Parent)_____give permission and consent for my (child)_____
DOB ____/____/_____ to receive the Seasonal Influenza Vaccine, FLUZONE QUADRIVALENT.
Mother's Maiden Name:_____
Parent Signature:_____Date:_____

Age	Vaccination Status	Dose	Schedule
6 months through 35 months	Not previously vaccinated with influenza vaccine or unknown vaccination history	Two doses, either 0.25ml or 0.5ml	Administer at least 4 weeks apart
	Previously vaccinated with influenza vaccine	One dose of 0.5ml. or Two doses of 0.25ml	If two doses administer at least 4 weeks apart.
36 months through 8 years	Not previously vaccinated with influenza vaccine or unknown vaccination history	Two 0.5ml doses	Administer at least 4 weeks apart
	Previously vaccinated with influenza vaccine	One or two 0.5ml doses	If two doses administer at least 4 weeks apart.
9 years and older		One 0.5ml dose	