**Flu Shot Consent Form**

**Please circle your response**

| | | |
|---|---|---|
| 1. Have had a flu shot before? | YES | NO |
| 2. Allergy to eggs? | YES | NO |
| 3. Currently taking an antibiotic for infection? | YES | NO |
| 4. Feel ill today or have a fever? | YES | NO |
| 5. Pregnant? | YES | NO |
| 6. History of GBS (Gillian Barre Syndrome) | YES | NO |

**Health History**

**Please check if the following applies**

_____Chronic heart disease

_____Chronic lung disease

_____ Diabetes mellitus

_____ Immunological Disorder or immunosuppressive medications

_____Renal disease

_____Sickle Cell Disease

_____ Spleen Removal

_____ 6 months or longer of an aspirin regimen

I hereby certify that the foregoing history is true and complete to the best of my knowledge, and I request the influenza vaccine. Further, I understand the risks of influenza vaccine, and ask that the vaccine be given to me or my child.

**Information about the person to receive the vaccine (please print)**

First Name_____ Middle Initial_____

Last Name_____

Address_____

City_____ State_____

Zip Code_____ Birthday_____

Age_____

Signature of Parent or Guardian _____

Date _____