ADULT FLU VACCINE CONSENT FORM
(18 YEARS AND OLDER)

Your child's Primary Care Physician _____ Patient I.D. _____

I, _____ _____ authorize consent to receive:
FULL NAME (PRINT) DOB

____ Flu Mist – Ages 2yr -49yr only, cannot have had MMR, VAR or MMRV within a month of getting Flu Mist.

____ Flu Shot

FOR CLINICAL USE ONLY

Lot Number _____ Exp _____

Administered By _____

The following questions will help us determine your eligibility to be vaccinated today. Please answer all questions.	**Yes**	**No**
• Is your insurance an HMO? **All HMO patients MUST receive shots at their PRIMARY CARE office ONLY)**		
• Do you have allergies to medications? (Examples: Gelatin, Gentamicin, Polymyxin, Neomycin) **If yes, please list allergies:**		
• Have you ever had a serious reaction to an influenza vaccine?		
• Have you had a seizure disorder for which you are on a seizure medication(s), a brain disorder, Guillain-Barre Syndrome (a condition that causes paralysis) or other nervous system problems?		
• Are you taking any anticoagulant therapy medications, including aspirin?		
• Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves or blood?		
• Do you have a weak immune system (for example, from HIV, cancer or medications such as steroids or those used to treat cancer?		
• Are you pregnant or nursing?		
• Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?		

****** I UNDERSTAND THAT IF MY INSURANCE DOES NOT COVER THE FLU SHOT OR IF I AM UNABLE TO PROVIDE MY INSURANCE CARD, I WILL BE RESPONSIBLE FOR THE COST OF THE FLU SHOT ******

_____ _____
SIGNATURE DATE

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Patients Only:

___ **I decline** the Flu Vaccination _____ _____
SIGNATURE DATE

Print Name_____