KAISER PERMANENTE®

Injectable Adult Flu Vaccine Consent, 19 yrs and older

Please answer the questions listed for the vaccine you will get today. If you answer "yes" to any of these questions, or don't know the answer, please don't sign this form without talking to your doctor or nurse. Please read the Vaccine Information Statements (VIS) we gave you for the vaccine you are getting today.

Name _____

Member I.D. Number _____

Date of Birth _____

Influenza Vaccine Card / Sticker

	YES	NO
• Has this person had a serious (life-threatening) allergic reaction to any previous dose of the vaccine(s) or vaccine components?	☐	☐
• Is this person sick now, or has this person been sick with a fever of 101 or greater?	☐	☐

Inactivated Influenza Vaccine (IIV)

• Has this person had an allergic reaction to eating eggs?	☐	☐
• Has this person had Guillian Barré Syndrome (GBS)?	☐	☐

I read the Centers for Disease Control and Prevention's Vaccine Information Statements (VIS). I had a chance to discuss the nature, alternatives, benefit, and risks of the vaccine(s) marked above. I've had a chance to ask questions and they were answered to my satisfaction. I consent to the administration of the vaccine(s) marked above.

I understand that flu vaccine is part of my preventive care benefit. If I owe a cost share, I will be billed for my portion.

Signature of person authorized to give consent _____ **Date** _____

FLU (INFLUENZA) VACCINE	**MANUFACTURER**
☐ FluZONE, (6-35 months), Quad *SYRINGE*	☐ Sanofi-Pasteur
☐ FluZONE, (3-18 yrs), Quad *VIAL*	
☐ FluARIX/FluZONE, (3-18 yrs), Quad *SYRINGE*	
☐ FluLaval, (36+ months), Quad *VIAL*	☐ GSK
☐ FluARIX, (36+ months), Quad *SYRINGE*	

Administered by
(Signature & Title Required) _____ Date _____

Document lot number from box next to vaccine administered