

INFLUENZA VACCINE CONSENT FORM

Patient Name: _____

_____ ("Provider") offers the **Influenza ("Flu") Vaccine** annually. This vaccine should not be given to anyone who is allergic to eggs or has had a reaction to flu vaccines before. If you decide to take the **Flu Vaccine**, you may experience some slight discomfort, soreness of the arm, redness of the arm, fever, Flu-like symptoms, or muscle aches, and in rare occasions, Guillain-Barré Syndrome. I have read, or have had explained to me, the CDC Vaccine Information Statement about the **Flu Vaccine**. I have had the opportunity to ask questions regarding the **Flu Vaccine**, and those questions were answered to my satisfaction.

If you consent to the **Flu Vaccine** but later change your mind, you may revoke this consent at any time. Provider must have your consent before it can administer the vaccine.

Thank you for your cooperation in this matter.

- I consent to receive the **Flu Vaccine**.
- I consent to receive the **Flu Vaccine** at another time.
- I do not consent to receive the **Flu Vaccine**.

Reason for decline:

- _____ Already received [Date: _____]
- _____ Allergic
- _____ Not interested
- _____ Other

By signing below, I acknowledge that I have received information on the **Flu Vaccine** and the reasons why the **Flu Vaccine** is being recommended at this time. Acknowledging that this information has been provided to me, I understand the risks versus the benefits of the **Flu Vaccine** and have made the above indicated decision with respect to receiving the **Flu Vaccine**. If I have elected to not receive the **Flu Vaccine** or to receive the **Flu Vaccine** at another time, I understand the risks associated with this decision and will not hold Provider or Provider's representatives accountable if I contract the **Flu**.

PATIENT/PARENT SIGNATURE:

Print Name: _____

Relationship to Patient: _____