

Dahl Memorial Clinic

Municipality of Skagway

PO Box 537, 350 14th Ave. Skagway, Alaska, 99840

Phone (907) 983-2255 - Fax (907) 983-2793



CONSENT FORM FOR SEASONAL INFLUENZA (FLU) VACCINE

I've read, or had explained to me information about influenza and influenza vaccine. I have had an opportunity to discuss the benefits and risks of influenza vaccine & to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given as indicated.

Patient Name: _____
Please Print: (First) (MI) (Last)

Date of Birth: ____/____/____ **Age:** _____

Parent/Guardian's Name (if applicable): _____
Please Print: (First) (Last)

- Has the person receiving the vaccine ever had a severe allergic (hypersensitivity) reaction to eggs, chickens, or chicken feathers? **YES** **NO**
- Does the person receiving the vaccine have a history of Guillain-Barré syndrome or a persistent neurological illness? **YES** **NO**
- Has the person received a live vaccine within the past 30 days (ie MMR, RotaTeq/Rotarix)? **Yes*** **No** *If **YES**, it is recommended to space live vaccines by ≥ 4 weeks for full efficacy.
- Is the person receiving the vaccine allergic to Neomycin, Thimerosal (preservative found in contact lens solution), or latex? **YES** **NO**
- For children 6 mo – 8 yrs: Have they received 2 or more doses of influenza vaccine before July 2023? **YES** **NO** *If **NO**, the CDC recommends 2 vaccinations (at least 4 weeks apart) for the best protection against flu.

Signature: Person receiving vaccine OR Parent/Guardian

Date

DO NOT WRITE IN THIS SPACE-OFFICE USE ONLY

- .5mL IM Influenza 6mo-18yrs
- .5mL IM Influenza Adult
- Senior >65yrs High Dose Fluzone IM
- Intranasal Flumist 2-49yrs

L/R Deltoid

L/R Thigh

PLACE LOT LABEL BELOW: