155 Crystal Run Road
Middletown, NY 10941
845-703-6999

61 Emerald Place
Rock Hill, NY 12775
845-794-6999

Flu Vaccine Consent Form

Date: _______

This form will acknowledge your consent for administration of the Flu Vaccine and identify any precautions or contraindications you may have for administration of this immunization. Please be advised we recommend you wait for fifteen minutes prior to leaving our office after your flu vaccine. Please provide all requested information and signature. Please use this copy to notify your provider that you received the vaccine if necessary.

Precautions and Contraindications (Please circle Yes or No)

Are you allergic to the Flu vaccine or any of its components?	Yes	No
Are you sick today?	Yes	No
Do you have a history of Guillain-Barre Syndrome?	Yes	No
Have you ever had an adverse reaction to influenza or any other vaccine?	Yes	No

Patient Name: ____

Date of Birth: ____

Signature: ____

Office Use Only:

Dose: _______Side: ________Site: ________MFR: ______________Lot #: _______

Exp. Date: ______________________

Nurse (Print Name): ______________________________________

Nurse Signature: ______________________________________

Provider name:______________________________________