

# Influenza Immunization Consent Form

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M or F  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Doctor's Name: \_\_\_\_\_  
Doctor's Address (Town): \_\_\_\_\_

## **Payment** (CHECK ONE):

- Medicare Number: \_\_\_\_\_  
 Commercial Insurance \_\_\_\_\_  
 Self Pay: \_\_\_\_\_  Town Pay: \_\_\_\_\_  
Amount Paid Write in town name

## YOU MUST ANSWER THE FOLLOWING QUESTIONS:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Have you ever had a serious reaction to the FLU Vaccine | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Are you allergic to EGGS?                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Are you allergic to THIMEROSAL?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have you ever had GUILLAIN BARRE SYNDROME?              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Are you SICK with a FEVER today?                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

## **INFLUENZA CONSENT:**

I have read, or had explained to me, the information sheet about influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that the flu vaccination be given to me (*or the person named above for whom I am authorized to make the request*). I authorized the release of any medical or other information necessary to process a Medicare claim or for other health purposes.

\_\_\_\_\_  
**Signature of recipient (or parent or guardian)**

Injection Site:  Left Arm  Right Arm

Manufacturer & Lot Number \_\_\_\_\_

\_\_\_\_\_  
Nurse Signature

\_\_\_\_\_  
Date

 **MIDDLESEX**  
**HOSPITAL HOMECARE**  
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