INFLUENZA VACCINE QUESTIONNAIRE/CONSENT FORM

Premier Urgent Care Center
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PLEASE PRINT

Full Name:	**ADDRESS:**
DOB:	**City, State Zip Code:**
Contact Phone Number:	**Legal Guardian (if patient less than 18 years old)**

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Is the person to be vaccinated sick today? ○ **YES** ○ **NO** ○ **DON'T KNOW**

2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? ○ **YES** ○ **NO** ○ **DON'T KNOW**

3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? ○ **YES** ○ **NO** ○ **DON'T KNOW**

4. Has the person to be vaccinated ever had Guillain-Barré syndrome? ○ **YES** ○ **NO** ○ **DON'T KNOW**

5. Is the person to be vaccinated pregnant (or think you may be) or breastfeeding? ○ **YES** ○ **NO** ○ **DON'T KNOW**

Acknowledgement and Waiver

I, the undersigned, wish to receive a vaccination against influenza. I am taking this vaccine voluntarily and consent to the vaccination being given to me. I have read the information provided (document entitled inactivated Influenza vaccine fact sheet). I understand the risks and benefits of this vaccine. I am aware of the strong recommendation to remain in the clinic for 20 minutes after receiving the vaccine. I have had an opportunity to ask questions which have been answered to my satisfaction. I hereby waive any claim for damages that I (or anyone claiming on my behalf) may have against Premier Urgent Care Center, its directors, employees and agents on account of any injury or misfortune I may suffer as a result of this vaccination.

Form completed by:_____ Date:_____
Print and sign name

Form reviewed by:_____ Date:_____
MD ARNP PA MA

Vaccine injection site: Deltoid, IM ○ **right** ○ **left**

Supervising Healthcare Provider:_____