

FLU VACCINE CONSENT FORM

WHEATON SANFORD CLINIC

FLU VACCINE CLINIC

Name _____ Birthdate _____

Please answer the following questions

- | | | |
|--|-----|----|
| 1. Is the person to be vaccinated sick today? | Yes | No |
| 2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine? | Yes | No |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | Yes | No |
| 4. Has the person to be vaccinated ever had Guillian-Barre syndrome? | Yes | No |
| 5. Has the person to be vaccinated ever felt dizzy or faint before, during or after a shot? | Yes | No |
| 6. Is the person to be vaccinated anxious about getting a shot today? | Yes | No |

Payment information:

☐ \$122.00 cash or check payable to Sanford Wheaton Medical Center **(Do not bill insurance)**

☐ Bill the following insurance:

Insurance Company: _____

Insurance Subscriber Name: _____ Birthdate: _____

ID Number: _____ Group Number: _____

I received a copy of the INFLUENZA VACCINE INFORMATION STATEMENT.

I give permission for Sanford Wheaton to give flu vaccine.

Signature: _____ **Date:** _____

For office use only:

DATE		VACCINE NAME	Influenza Vaccine
EXPIRATION DATE		SITE	Left Arm / Right Arm
LOT #		ROUTE	IM
VIS DATE	1/31/25	NURSE SIGNATURE	
☐ Flucelvax (6mo-64yrs) CPT 90661			
☐ Fluad High Dose (65+yrs) CPT 90653			