Harrison County General Health District
Seasonal Influenza Vaccine Consent

PATIENT'S NAME: (Last)	(First)	(M.I.)	PATIENT'S DATE OF BIRTH:
PATIENT'S ADDRESS:			PATIENT'S GENDER: ☐ FEMALE ☐ MALE
CITY:	STATE:	ZIP:	PHONE:

Please Answer the Following Questions:	YES	NO
Is this the patient's very first influenza vaccine?	☐	☐
Has the patient ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
Is the patient ill with fever today?	☐	☐
Does the patient have a serious allergy to eggs?	☐	☐
Does the patient have an allergy to latex?	☐	☐
Has the patient ever had Guillain-Barré Syndrome?	☐	☐
Does the patient have any allergies or serious medical condition[s] such as Heart Disease, Diabetes, Kidney Disease, Asthma or other Pulmonary Disease?	☐	☐
Does the patient have any other medical condition not disclosed on this form?	☐	☐
Is the patient pregnant? N/A ☐ YES ☐ NO ☐	If yes, does patient have a *Written Doctor's Order* for influenza vaccine?	☐	☐

Staff Use Only
Place FRONT of Insurance Card here & scan

Insurance Provider:	YES	NO
Is the patient covered by Medicare or Medicaid?	☐	☐
Is the patient self paid?	☐	☐
Does the patient qualify for an ODH supplied vaccine?	☐	☐

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By signing this form, I agree to the following:

I understand that there is always a possibility of an adverse reaction to any vaccine or drug. To the best of my knowledge I understand the benefits and risks of the seasonal influenza vaccine. I have had the opportunity to review the CDC Vaccine Information Sheet and do herby request to receive this vaccine for myself, my minor child, or person that I have legal guardianship over. I understand that no personal information about me will be released except for reporting purposes only to the Ohio Department of Health and the Centers for Disease Control and Prevention.

If other than actual patient, please specify relationship:	☐ Parent	☐ Legal Guardian	☐ Other*_____

Patient Signature: _____Date: _____

~*~*~*~*~*~*~*~*~*~*~*~*~*~*~*~ **Staff Use ONLY Below This Line**~*~*~*~*~*~*~*~*~*~*~*~*~*~*~*~

Nursing Staff Only:

Vaccine	Expiration Date	VIS Date	VIS Given?	
Fluarix	06/30/2022	8/6/2021	Yes ☐	No ☐

LOT #	MFG	Administration Site		
		LD	RD	Other
PH7C2	GSK	☐	☐	☐ *_____

_____ _____

HCGHD Staff Signature / Title Date