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?	☐	☐
Is the patient taking blood thinners or at risk for bleeding?	☐	☐
Does the patient have any other medical condition causing lower immunity?	☐	☐

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:

Staff Use Only
Place BACK of Insurance Card
here & scan

Vaccine	Expiration Date	VIS Date	VIS Given?	
Fluarix Quadrivalent	06/30/2024	8/15/2019	Yes ☐	No ☐

LOT #	MFG	Administration Site		
		LD	RD	Other
AF749	GSK	☐	☐	☐ *_____

_____ _____

HCGHD Staff Signature / Title Date