
# WELLNESS CENTER

1174 Live Oak Boulevard
Yuba City, CA 95991
Phone: (530) 822-5500 Fax: (530) 822-5503

## ADULT - Influenza Vaccine Consent Form

**Name:**_____ **Phone:** _____ **DOB:**_____

| Screening Questionnaire | Yes | No | Don't Know |
|---|---|---|---|
| **Are you sick today?** | | | |
| **Do you have a sensitivity to eggs, egg products, or thimerosal - (a mercury derivative used as a preservative)?** | | | |
| **Have you ever had a serious reaction to the flu vaccine in the past?** | | | |
| **Have you had Guillain-Barré syndrome?** | | | |
| **Are you pregnant, nursing, or intend to become pregnant?** | | | |
| **Are you over Age 65?** | | | |

## Consent Given By Patient

I,the undersigned patient, parent or guardian, have read the information about the seasonal influenza vaccine ("Vaccine") as outlined on the Vaccine Information Statement. I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the Vaccine.I am aware it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Serious reactions called "anaphylaxis" can be life-threatening medical emergencies. Symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. If I experience such symptoms following my vaccination, I'm aware it may require the administration of epinephrine, diphenhydramine, beta agonists, and or antihistamines to treat this reaction and 911 will be called to provide additional assistance. I hereby request the influenza vaccine for the 2021-2022 influenza season be given to myself or the person for whom I am authorized to give consent.

❑ **I confirm that I want to receive the seasonal influenza vaccine**

| _____ | _____ | _____ |
|---|---|---|
| ***Print Name*** | ***Signature*** | ***Date*** |

## Wellness Center Use Only

| | | |
|---|---|---|
| ❑ **Fluarix Quadrivalent- GSK** 0.5mL IM | ❑ **Fluad (High-dose)-Seqirus** 0.5mL IM | ❑ **Flucelvax (cell-based)- Seqirus** 0.5mL IM |
| **Manufacturer:** | **Expiration:** | **Lot #:** |
| **Administration site:** | ❑ **Right deltoid** | ❑ **Left Deltoid** |
| **Administered By:** | | |

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## Pediatric - Influenza Vaccine Consent Form

**Name:**_____ **Phone:** _____ **DOB:**_____

| Screening Questionnaire | Yes | No | Don't Know |
|---|---|---|---|
| **Is your child between 6 months - 8 years of age?** | | | |
| **Has your child had the Influenza vaccine before?** | | | |
| **Has your child had a serious reaction to the flu vaccine in the past?** | | | |
| **Is your child sick today?** | | | |
| **Does your child have an allergy to eggs?** | | | |
| **Has your child had Guillain-Barré syndrome?** | | | |

For children 6 months of age to 8 years of age, **if this is your child's first year receiving the vaccination**, please mark below if this is their first or second dose of seasonal influenza vaccine this year? ❑ **First** ❑ **Second**

If second, please indicate the date of the first dose: _____

## Consent Given By Patient

I,the undersigned parent or guardian, have read the information about the seasonal influenza vaccine ("Vaccine") as outlined on the Vaccine Information Statement. I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the Vaccine.I am aware it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Serious reactions called "anaphylaxis" can be life-threatening medical emergencies. Symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. If I experience such symptoms following my vaccination, I'm aware it may require the administration of epinephrine, diphenhydramine, beta agonists, and or antihistamines to treat this reaction and 911 will be called to provide additional assistance. I hereby request the influenza vaccine for the 2021-2022 influenza season be given to myself or the person for whom I am authorized to give consent.

❑ **I confirm that I want my child to receive the seasonal influenza vaccine**

_____ _____ _____

***Legal Guardian Name*** ***Signature*** ***Date***

## Wellness Center Use Only

❑ **Quadrivalent**
0.5mL IM

❑ **Flucelvax Quadrivalent - Cell Based ***
0.5mL IM *** ONLY IF > 4 years of age**

| **Manufacturer:** | **Expiration:** | **Lot #:** |
|---|---|---|
| **Administration site:** | ❑ **Right deltoid** | ❑ **Left Deltoid** |
| **Administered By:** | | |