Ledge Light Health District
Seasonal Influenza Vaccine Consent and Administration Record

Full Name _____

Address _____ _____ ____ _____
Street Town State Zip Code

Phone _____ Date of Birth _____ Age ____ Gender _____

Race _____
(Native American or Alaskan, Asian, African American or Black, Native Hawaiian or Pacific Islander, White, Other or Multiracial)

Ethnicity _____
(Hispanic/Non-Hispanic/Unknown)

Allergies _____

Please Answer The Following Questions:

☐ Yes ☐ No Are you sick today?
☐ Yes ☐ No Are you 18 years or older?
☐ Yes ☐ No Have you ever had an influenza vaccine?
☐ Yes ☐ No Have you ever had a serious reaction to an influenza vaccine in the past?
☐ Yes ☐ No Do you have an allergy to an ingredient of the vaccine?
☐ Yes ☐ No Have you ever had Guillain-Barré Syndrome?

Consent:

I have read or had explained to me the Vaccine Information Statement (VIS 8/6/21) about the influenza vaccine. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the influenza vaccine as described. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I authorize the release of any medical or vaccination administration information necessary for documentation purposes, including reporting to applicable vaccine registries such as CT Wiz and VAERS, and/or in order to provide treatment, and/or in the ev01ent of a medical emergency.

Signature _____ **Print Name** _____ **Date** _____

For Clinic Use:

Dosage/Route: ☐ 0.5 mL intramuscular injection

Vaccine Manufacturer and Lot #:

Site: ☐ right deltoid ☐ left deltoid

Administered by: _____ Date: _____