Flu Vaccine Consent Form

DATE: _____

Please circle your response

1. Have you had a flu vaccine before?	Yes	No
2. Do you have a history of anaphylaxis?	Yes	No
3. Are you allergic to eggs, neomycin or polymyxin?	Yes	No
3. Are you currently taking an antibiotic for infection?	Yes	No
4. Do you feel ill today or do you have a fever?	Yes	No
5. If you are female, are you pregnant?	Yes	No
6. When did you last receive any Covid vaccine or booster?	_____	

I hereby certify that the foregoing history is true and complete to the best of my knowledge, and I request the influenza vaccine. I understand the benefits and risks of influenza vaccine, and ask that the vaccine be given to me.

Information about person to receive vaccine (please print) Must be completed by the receiver of vaccine.

Names _____

Surname _____

Contact number _____

Date of Birth _____

Signature _____

For use of Registered Nurse

Qualification _____

Initials and Surname _____

Signature _____

Site of injection Deltoid LEFT RIGHT