CONSENT FOR INACTIVATED INFLUENZA VACCINE

Cotton O'Neil Doctor________________________________

1. Have you had a fever greater than 100^0 F within the last 24 hours? ☐ **yes** ☐ **no**

2. Have you ever had a flu vaccine in the past? ☐ **yes** ☐ **no**

3. Have you ever had a reaction to the flu vaccine in the past? ☐ **yes** ☐ **no**
   If yes, describe____

4. I consent to have this vaccine information included in the Kansas Immunization Registry (WebIZ). ☐ **yes** ☐ **no**

If You Have a Severe Reaction or one Lasting More than 24 Hours – See Your Doctor!

I have been given the CDC Vaccine Information Sheet dated 08/15/2019.
I understand benefits and risks of influenza vaccinations as described.
I request that the vaccine be given to me or to the person named below for whom I am authorized to sign.

NAME:____ Age:__________Birthdate:______________
(**PRINT**)

ADDRESS____
Street City State Zip

PHONE NUMBER:___________________________

X____ ____________________
SIGNATURE OF PERSON TO RECEIVE VACCINE DATE
(OR PARENT OR GUARDIAN)

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(For Office Use Only)

FLULAVAL
(Circle correct lot/expiration or write information)
Lot # NY927 / Exp 06/30/2021

Lot # ________________________ / Exp _______________

FLUAD
(Circle correct lot/expiration or write information)
Lot # 279800 / Exp 6/16/2021

Lot # ________________________ / Exp _______________

Injection Site: L deltoid ⓧ R deltoid ⓧ L vastus lateralis ⓧ R vastus lateralis ⓧ

Other___________________________

Given by____ **Date** ________________________