Name:
DOB: Patient Sticker
MRN:

Stormont Vail Health

Stormont Vail Health
FLINT HILLS CAMPUS

Stormont Vail
OB/GYN
LINCOLN CENTER

1991

CONSENT FOR INACTIVATED INFLUENZA VACCINE

Stormont Vail Health 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**

<u>If You Have a Severe Reaction or One Lasting More Than 24 Hours – See Your Doctor!</u>

I have been given the CDC Vaccine Information Sheet. 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)

(For Office Use Only)

FLUCELVAX
(Circle correct lot/expiration or write information)
Lot # 418660 / Exp 06/30/2027

Lot # _____ / Exp _____

FLUAD
(Circle correct lot/expiration or write information)
Lot # 418661 / Exp 06/09/2027

Lot # _____ / Exp _____

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

Other_____

Given by:_____ **Date:**_____