

# The Huxford Clinic

## Influenza Vaccine Consent

### Consent

I **DO NOT** have any of the conditions listed below:

- Serious allergy to eggs
- Serious reaction to previous flu vaccine
- History of Guillain-Barré syndrome
- Moderate or severe illness

I understand that there are risks associated with any medication. The risks from the vaccine are much smaller than the risks from the disease.

I understand that Huxford Pulmonary or any persons acting as their agent are not responsible for any adverse reactions that I sustain.

I have been offered information on influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction. I consent to the administration of the influenza virus vaccine.

*Signature:* \_\_\_\_\_

Print Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_



Date Vaccinated: \_\_\_\_\_ Influenza vaccine 0.5 ml given in \_\_\_\_ deltoid by \_\_\_\_\_

Regular Dose: Manufacturer: \_\_\_\_\_ Lot# \_\_\_\_\_ Exp: \_\_\_\_\_

High Dose: Manufacturer: \_\_\_\_\_ Lot # \_\_\_\_\_ Exp: \_\_\_\_\_