Immediate Care Center

243 Cheney Drive W. Suite 200
Twin Falls, ID 83301
Phone: (208) 736-8905

Vaccine Consent Form-FLU SHOT/ Pneumonia

Section 1: Information about Patient to Receive Vaccine (please print)

NAME (Last)	(First)	(M.I.)	DATE OF BIRTH month _________ day _________ year _________

AGE	GENDER M / F	ADDRESS

CITY	STATE	ZIP

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if you can get the seasonal influenza vaccine. If you answer "NO" to all four of the following questions, you can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, you may be able to get the seasonal influenza vaccine, but we will contact you to discuss your options.
Please mark YES or NO for each question.

	YES	NO
1. Do you have a serious allergy to eggs?		
2. Do you have any other serious allergies? Please list: ____		
3. Have you ever had a serious reaction to a previous dose of flu vaccine?		
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

Section 3: Consent

CONSENT FOR VACCINATION:

I have read or had explained to me the 2018-2019 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

Signature of Patient, Parent/Legal Guardian ____

Date: month: ______day: ______year: ____________

Section 5: Vaccination Record

~Please see chart for record~