MIDDLETOWN TWP HEALTH DEPT

INFORMED CONSENT FOR RECEIPT OF SEASONAL INFLUENZA VACCINE

	Please Circle	
I currently have a fever, symptoms of infection OR on antibiotics	Yes	No
I have a history of Multiple Sclerosis (MS)	Yes	No
If answer Yes to above question, ask. I am under a doctor's supervision and/or treatment.	*Yes*	*No*
Have I ever gotten the Pneumococcal vaccine? What year, if known:	Yes	No
Did I have the Flu vaccine last year?	Yes	No
I am pregnant? If answer yes. 1st trimester 2nd trimester 3rd trimester	Yes	No
I am taking Coumadin or other prescription blood thinning medicine	Yes*	No

* **If yes**, please answer the questions on reverse side

I've read or had explained to me the information about influenza disease, the vaccine, and special precautions. I've had an opportunity to ask questions about influenza disease, and the specific vaccine which questions were answered to my satisfaction and I hereby certify that I am 18 years of age or older.

To my knowledge either I or the person I am authorized to make the request for are not allergic to chicken eggs or chicken egg products, Gentamicin or Thimerosal (merthiolate, found in some contact lens solutions) and have never been advised by a physician not to receive the Influenza vaccine. I am not allergic to epinephrine (adrenaline) or Benadryl (diphenhydramine) – drugs used to counteract an allergic reaction to a flu shot. If I am taking coumadin or another prescription blood thinner, I have completed the screening survey on the reverse side of this sheet before receiving the Influenza vaccine.

I hereby acknowledge that I had the opportunity to receive the federal HIPAA notice of privacy information sheet, along with the Vaccine Information Statements for Inactivated Influenza Vaccine (8/6/21).

I believe I understand the benefits and risks of the Influenza vaccine and I request and consent that it be given to me or to the person named below of whom I am the parent, guardian or authorized person.

Signature: _____ ***Date:*** _____

Person receiving vaccine.

Last Name: _____ **First Name:** _____ **MI:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone#: ( ) _____ **Birth Date:** _____ **Sex: M or F**

MARITAL STATUS: Single Married Divorced Widow (Circle One) **Age:** _____

Influenza Vaccine Lot #: _____ Manufacturer: _____ Date Vaccine Given: _____

Site of Injection: left arm ( ) right arm ( ) Clinic Site: _____

Signature Nurse who administered: _____

NOTICE TO CLIENTS ON COUMADIN or PRESCRIPTION BLOOD THINNERS

Anyone taking the above agents may be at increased risk for complication (that is, excessive bleeding at injection site) from receiving an injection. If you have a concern about this, please consult your private physician before receiving a flu and / or pneumonia vaccine injection.

Specifically, individuals who may have one or more of the following should NOT receive the flu and / or pneumonia injection without their doctor's permission.

		YES	**NO**
1.	I started taking Coumadin / prescription blood thinners within the past month.	_____	_____
2.	I have experienced unusual bleeding.	_____	_____
3.	I have tested positive for blood in my urine and / or stool.	_____	_____

I have been monitored by my physician within the past two (2) months and I hereby certify that I do not presently have any of the above conditions.

_____ _____

SIGNATURE ***DATE***