Premise Health™
Keep your edge.

Inactivated Influenza Vaccine Authorization and Consent
(≥ 18 years of age)

Name (Print) _____ Date of Birth: _____/_____/_____ Phone No. _____

_____
Street Address City State Zip Code

The influenza vaccine is prepared using a combination of strains of both the influenza A and influenza B viruses based upon the recommendations of the Centers for Disease Control and Prevention (CDC) and the Advisory Council on Immunization Practices (ACIP). This vaccine is prepared using an inactivated/killed form of the flu virus and it is therefore impossible for the vaccine to cause the flu. Possible side effects of the vaccine are included on the Vaccine Information Statement.

Please answer the following questions:

Have you ever received the influenza vaccine?	☐ Yes	☐ No	
Are you now, or could you possibly be, pregnant?	☐ Yes	☐ No	☐ N/A
Are you allergic to latex, thimerosal, eggs or egg products?	☐ Yes	☐ No	
Have you ever had an allergic reaction to the flu vaccine or other vaccine?	☐ Yes	☐ No	
Are you currently sick or have a fever?	☐ Yes	☐ No	
Have you ever had Guillain-Barré Syndrome or other neurological (nervous system) disorder?	☐ Yes	☐ No	

I have read the provided influenza Vaccine Information Statement, and have had any questions answered to my satisfaction. I believe that I understand the benefits and risks of the influenza vaccine and request that the vaccine be administered to me. I acknowledge that no guarantees or assurances have been made to me concerning the results of administration of the vaccine. I release _____, and Premise Health and its employees from any liability for any adverse reaction to the vaccine.

I acknowledge that I have been given the opportunity to receive the Premise Health Notice of Privacy Practices ("Notice") regarding uses and disclosures of information regarding me and my health ("Health Information"), and a copy of this Notice can be provided to me.

Recipient Signature: _____ Date: _____/_____/_____

NOTE: If you have never received a flu vaccine, it is recommended that you wait in the clinic/administration area for 15 minutes after receiving the injection. If this is your first flu vaccine, and you choose not to wait, please initial on the following line.

_____
Initials

Brand Name	
Manufacturer	
Lot Number	
Expiration Date	_____/_____/_____

Dose	0.5 ml	
Injection Site	Deltoid	
	☐ Right	☐ Left

VIS, dated 08/07/2015, provided and vaccine administered on _____/_____/_____ , at _____:_____ a.m. / p.m. by:

_____ _____
Staff Member Printed Name Staff Member Signature