STAFF VACCINATION CONSENT FORM
FLU SHOT

NAME (Last)	(First)	DATE OF BIRTH / /
ADDRESS		Home Phone:
		Cell Phone:
DOCTOR'S NAME		PRIMARY CLINIC

INSURANCE
□ **(Circle One) – Medicaid / MA / Blue Plus / UCare / Prime West**
□ **Private Insurance** _____
□ **No Insurance**

The following questions will help us to determine if you may receive the FLU SHOT(inactivated influenza vaccine).

Please mark YES or NO for each question.	**YES**	**NO**
1. Have you received a flu vaccine in the past?		
2. Have you ever had a serious allergic reaction to eggs or to a component of any flu vaccine?		
3. Have you ever had a serious reaction to a previous dose of flu vaccine?		
4. Have you ever had Guillain-Barre Syndrome (a serious nervous system disorder)?		

If you answered YES to questions 2-3-4 above, left any questions blank, or you are unsure of the answer to any of the questions above, you may NOT receive the FLU SHOT (please talk to your doctor).

CONSENT FOR VACCINATION: I have received and read the 2016 Vaccine Information Statement for the FLU SHOT. I understand the risks and benefits, and give my consent to receive the FLU SHOT. I also consent to having information regarding my influenza vaccination shared with my doctor and my health insurance company.

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

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