Influenza Vaccination Consent Form

Please provide the following information about the person to receive vaccine.

Last Name: _____ First Name: _____Middle_____

Birth Date: ____ / ____/ _____ Age: _____ ☐ Male ☐ Female
mm day year

Address: _____Telephone #_____

City_____ Zip_____ Mother's Maiden Name_____

Please circle one: Creek Citizen Non-Creek Native Non- Native

Please circle your answers to the following questions:
(1-3 Permanent Contraindication)

1. Are you sick or running a fever today?	**YES**	**NO**
2. Do you have an allergy to an ingredient of the vaccine?	**YES**	**NO**
3. Have you had a serious reaction to the flu vaccine in the past?	**YES**	**NO**
4. Have you ever had Guillain Barré syndrome?	**YES**	**NO**
5. Have you ever felt dizzy or faint before, during, or after a shot?	**YES**	**NO**
6. Are you anxious about getting a shot today?	**YES**	**NO**

☐ **Yes, I would like to have the Flu Vaccination (influenza) given to me** and I have been given the current vaccine information statement (VIS). I have had the opportunity to read, discuss the information, and to ask questions regarding influenza, the vaccine, the associated risks and benefits. I consent to the immunization being entered into the Oklahoma State Immunization Information System (OSIIS), my electronic health record, and/or employee health file and I consent to having this billed to my Medicare, Medicaid, or Private Insurance account.

Signature: X_____ Date: _____

MCN EMPLOYEES ONLY:

Please circle the division you work for: HEALTH TRIBAL CASINO

Employee number: _____ Facility you work at: _____ Department: _____

*I have a medical condition that contraindicates receiving the Influenza vaccination. I understand that I must wear a mask in patient care areas during the flu season. *Employee must provide Employee Health with a copy of the providers note. Date of provider note: _____ Provider: _____

***Do Not Write Below This Line* FOR CLINIC USE ONLY**

Vaccine Manufacturer:_____ Lot #: _____ Exp. Date: _____

Site: Left Deltoid Right Deltoid Dose: 0.5 ml – IM injection Location: _____

Signature of Nurse Administering Vaccine: _____ Date: _____

VIS Date: _____ EPIC encounter made _____ EPIC documented _____

https://www.immunize.org/catg.d/p4066.pdf