ImmPRINT Entry Date: (mm/dd/yy) __ __/__ __/__ __ Initials: _____

Influenza Vaccine Consent Form
Mass Vaccination Clinic
PATIENT INFORMATION

Personal information about individual to receive the vaccine					
Last Name	First Name		M.I.	Gender (circle) Male Female	
Date of Birth	Age	Last 4 digits Social Security #	Telephone Number		Alternate Number
Street Address			Apt. Number		
City	County		State	Zip Code	

PARENT/LEGAL GUARDIAN INFORMATION FOR DEPENDENTS

Last Name	First Name	Relationship to Patient (select) ☐ Parent ☐ Legal Guardian ☐ Other _____		
Street Address if different	Apt. Number	City	State	Zip Code
Telephone Number		Emergency Contact		

VACCINATION AND HEALTH RELATED INFORMATION

	Circle	
Has the patient ever received the flu vaccine?	Yes	No
Does the patient have long-term health problems with: Heart Disease Lung Disease Asthma Kidney or Liver Disease Metabolic Disease such as Diabetes Anemia and other Blood Disorders	Yes	No
Does the patient have any life-threatening allergies, including a severe allergy to food (including eggs), a vaccine component, or latex? If YES, explain:	Yes	No
Has the patient ever had a severe reaction after a dose of Influenza (flu) vaccine?	Yes	No
Has the patient had Guillain-Barre Syndrome (a severe paralytic illness, also called GBS)?	Yes	No

I have read or have had explained to me the information in the Vaccine Information Statement (VIS) about Influenza Vaccine and a VIS has been provided to me. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of Influenza Vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I have received notice of my privacy rights and I have been offered a copy of the Jefferson County Department of Health "Notice of Privacy Practices". I understand I can also access this information on JCDH's website. I understand my information and vaccine(s) I receive will be entered into the Alabama Department of Public Health Immunization Registry. I waive and release all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Jefferson County Department of Health, and their respective directors, officers, employees, and agents for any damage or injuries if I, or the person named above for whom I am authorized to make this request, contract Influenza, other diseases, or suffer any other adverse reactions following administration of this Influenza Vaccine.

Signature of Individual/Parent/Legal Guardian _____ Date _____

FOR CLINIC USE ONLY

Clinic Site	County Code	Date VIS Given	Type and Date VIS	If Vaccine Contraindicated Indicate why:	
Vaccine Given (CIRCLE):	Date Vaccine Given	Dosage	Route IM	Site (Circle) LA RA Other:	JCDH Patient **Yes No**
Manufacturer	Lot #	NDC#	Exp. Date		
Immunizer Signature	Title	Date			

NOTES: