CHRISTUS Primary Care South Bossier

CHRISTUS Physician Group

CPG Inactivated Influenza Vaccine Consent

Name of Practice/Location: _____

Name of Person to be Immunized: _____ Date of Birth: _____

Please circle yes or no for the following screening questions:

Yes No Are you sick or do you have a fever today?

Yes No Are you allergic to chicken eggs, egg products, Thimerosal or any vaccine component?

Yes No Have you ever had a severe allergic reaction to a previous flu vaccination?

Yes No Do you have a history of Guillain-Barre Syndrome (GBS)

I certify that I am at least 18 years of age and voluntarily give my signed permission for this vaccine. I have read or have had explained to me the information in Influenza Vaccine Information Statement (VIS). I have had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine. By signing below, I give my consent for CHRISTUS Physician Group to administer the influenza vaccine to me or my minor child, as identified above. I release CHRISTUS Physician Group and its affiliates from responsibility of any reaction resulting from the vaccine, and I take full responsibility to seek medical attention should serious reactions occur.

Date: _____

Patient or Guardian Printed Name: _____

Patient or Guardian Signature: _____

For Office Use Only – not required if documenting in an EHR
Administration Record for Influenza Vaccine

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

Dosage: 0.5 cc
Route: IM Site: ____Right Deltoid ____Left Deltoid

☐ Check box if no adverse patient reaction.

Administered by: _____ Date: _____
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