Flu Vaccination Consent Form

I, _____, Consent to the administration of Flu Vaccine. I am aware that some people experience pain at the site of injection and some may experience fever.

I testify that I have none of the conditions listed below:

- A severe allergy to hen's eggs
- A sever reaction to a flu shot in the past
- A history of Gullian-Barre Syndrome (GBS) in the 6 weeks after getting a flu shot

Please add clinic stamp to the space below if applicable :

Name (print)_____

Signature_____

Date_____

To Be Completed by Person Administering Flu Vaccine

_____

Administered Date_____

Location Providing Flu Vaccine_____

Clinic Full Address_____

Phone Number_____

Site of Injection_____

Lot # and Dosage:_____

Manufacturer_____

Expiration Date_____

Administered By_____

Signature_____