CORE PHYSICIANS
The Art of Wellness

Influenza Vaccine Consent & Screening Questionnaire 2023-2024

Printed Patient Name	Date of Birth	Age	Primary Care Physician

1. Is the person to be vaccinated sick today?	☐ Yes ☐ No
2. Does the person to be vaccinated have an allergy to any component of the vaccine?	☐ Yes ☐ No
3. Has the person to be vaccinated ever had a serious reaction after receiving the flu vaccine or any vaccine?	☐ Yes ☐ No
4. Has the person being vaccinated ever had a neurological problem called Guillain-Barré syndrome?	☐ Yes ☐ No

I have read or have had read to me the CDC Vaccine Information Statement entitled, "Influenza Vaccine, What You Need to Know (Flu Vaccine, Inactivated) and have answered the above medical screening questions. I have had an opportunity to ask questions regarding this vaccine and they have been answered to my satisfaction. I understand the risks and benefits of seasonal influenza vaccination and request the vaccine be given to the patient named above.

X ---

Signature of Person Receiving Vaccination or Person's Legal Guardian

FOR CLINIC USE ONLY:

Children age 8 or younger who did not receive a total of two or more doses of trivalent or quadrivalent seasonal influenza vaccine, before July 1, 2023, (the two doses need not have been received during the same season or consecutive seasons) should receive a second dose of influenza vaccine at least four weeks after the first influenza vaccination for full protection against influenza.

Vaccine Manufacturer: GSK Lot #: _____ Exp Date: 30 June 24

Injection Site: ☐ Right Deltoid ☐ Left Deltoid ☐ Right Thigh ☐ Left Thigh Route: IM Dose: ☐ 0.5 ml

VIS dated: 08/06/2021

Signature and Title
of Vaccine Administrator X_____ Date: _____