

COMPLETION REQUIRED BY PATIENT

Please complete the following six questions

Attention: If you answer yes to any of the questions, further assessment is needed by the nurse.

1. Is this the first flu vaccination ever for the person to be vaccinated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is the person to be vaccinated presently ill with a fever, sore throat, or cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has the person to be vaccinated have an egg allergy, latex allergy or serious medication allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has the person to be vaccinated ever had a serious reaction after receiving a vaccinations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is the person to be vaccinated 65 years of age or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No

I have received, read, and understand the current Flu or FluMist VIS for the Vaccine provided by Hennepin Health Systems dba MVNA. I have had an opportunity to ask questions and received answers to my satisfaction. I understand the benefits and risks of the vaccination and expressly consent, request and authorize a nurse to administer the vaccine(s) to me. I agree to stay in the general area for fifteen (15) minutes after receiving my vaccination. If I experience any side effects, it is my responsibility to follow up with my physician at my expense. I hereby release Hennepin Health Systems dba MVNA, its officers, employees, agents; and _____, (company name), its officers, employees, and agents from any and all liability that might arise from vaccination on behalf of me, my heirs and personal representatives. I acknowledge that a copy of Hennepin Health Systems dba MVNA's Notice of Privacy Practices is available to me. I understand that this document provides an explanation of the way in which my health information may be used or disclosed by Hennepin Health Systems dba MVNA and of my rights with respect to my health information. I understand I am financially responsible to Hennepin Health Systems dba MVNA for any balance not covered by my insurance company(ies) indicated above.

Parent/Guardian Signature: 6 months – 17 years: _____

Print Name _____ **Relationship to Patient** Mother Father Other

I am the child's parent, authorized representative, or legal guardian and can provide effective consent for this immunization. If applicable, I authorize my child's school to designate a responsible adult to be present at the immunization and to provide direction or assistance if needed.

Client Signature: 18 and older _____ **Date:** _____

Print Name _____

NURSE ONLY

Manufacturer	Dose	Age	Site	Lot Number (Sticker)	Expiration Date
Fluzone/Sanofi Quadrivalent	<input type="checkbox"/> 0.25 ml	6 – 35 months	Anterolateral Thigh: L or R		
			IM Deltoid: L or R		
Fluzone/Sanofi Quadrivalent	<input type="checkbox"/> 0.5 ml	3 years & up	IM Deltoid: L or R		
FluaLaval/GSK Quadrivalent	<input type="checkbox"/> 0.5 ml	3 years & up	IM Deltoid: L or R		
HighDose Fluzone/ Sanofi	<input type="checkbox"/> 0.5 ml	65 years & up	IM Deltoid: L or R		

Vaccine Administrator Signature: _____

RN Name (Please Print): _____

Date: _____ Time: _____ am pm

Vaccine Information Statement (VIS) offered to client: (RN to check box) VIS Edition: ____ / ____ /2016