

**MASONBORO FAMILY MEDICINE**

**FLU CONSENT FOR TREATMENT**

Each person receiving the flu shot must complete form

**PATIENT INFORMATION:**

**NAME:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**AGE:** \_\_\_\_\_

**ARE YOU ALLERGIC TO EGGS? Y/N**

**HAVE YOU EVER HAD THE FLU SHOT? Y/N**

**ARE YOU PREGNANT? Y/N HOW MANY WEEKS? \_\_\_\_\_**

I have read/had explained to me the information about influenza and the influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the risks of the influenza vaccine and ask the vaccine be given to me or the person named above from whom I am authorized to make this request. I agree that Masonboro Family Medicine shall have no responsibility or liability if I contract influenza, other respiratory diseases, or suffer any other adverse reaction following administration of the flu shot.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**OFFICE USE ONLY**

**DATE OF VACCINATION:** \_\_\_\_\_

**MFG/LOT #: Flu Laval 18 and up: GSK AFLLA580CA 6/2011**

**Fluvirin 4 and up: Novartis 1117769P1 3/2011**

**Fluarix 3 and up: GSK**

**Fluzone 6months and up Sanofi UH181AC 6/30/2011**

**SITE: LT/RT ARM IM**

**LT/RT THIGH IM    Initials: \_\_\_\_\_**