RICHMOND
Family Medicine

Name		
DOB		
Is this your first time receiving the flu vaccine?	YES ☐	NO ☐
Are you feeling moderately or severely ill today (and/or do you have a fever)?	YES ☐	NO ☐
Are you allergic to eggs, egg products, or chicken protein?	YES ☐	NO ☐
Have you ever had a serious reaction to the influenza or any other vaccine in the past?	YES ☐	NO ☐
Have you ever had Guillain-Barre syndrome?	YES ☐	NO ☐

Consent: I have received and read the Vaccine Information Sheet relevant to the influenza vaccine. I have read the above information and have had an opportunity to ask questions. I understand the benefits, risks, and alternatives to flu vaccination as described. I request the vaccine be given to me or to the person for whom I am authorized to sign. I will communicate the information provided to me today about my vaccination to my primary care provider if other than provider at Richmond Family Medicine.

Signature of Recipient or Parent/Guardian:_____

Date_____