INTERMED
Care without compromise.

INFLUENZA VACCINE CONSENT & ADMINISTRATION FORM
2021 – 2022 FLU SEASON

Patient Name (Print Clearly): _____ DOB: _____/_____/_____ Age:_____

Phone Number: (_____) _____-_____ Primary Care Physician Name: _____

Review the statements below and **check those that apply to you**:

- ☐ I am allergic to eggs or egg products.
- ☐ I am sensitive to Thimerosal (a preservative used in some vaccines).
- ☐ I have a history of the neurologic disorder Guillain-Barré Syndrome.
- ☐ I currently have a fever, acute respiratory or other active infection or illness.
- ☐ This is my first ever flu vaccine and I am under 8 years old (requires booster after 28 days from first dose).
- ☐ None of the above.

----------STOP: FOR INTERNAL USE ONLY----------

☐ IIV4 Private 0.5ml ☐ IIV4 High Dose Quad Private (ages 65+) 0.7ml ☐ IIV4 Preserv. Free Private 0.5ml ☐ IIV4 Preserv. Free State 0.5ml ☐ RIV4 (Flublok Recombinant) Private 0.5mL	Intramuscular Injection Given: ☐ Left Deltoid ☐ Right Deltoid ☐ 8/6/2021 VIS Given to Patient
Administered By (Full name and Title):	*Date of Vaccine:*