Consent to Receive Injectable Influenza Vaccine (Flu Shot) 2020-2021

Name_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Phone Number_____

I have received, read and understand the Vaccine Information Statement called "Influenza (Flu) Vaccine (Inactivated or Recombinant)." I have had a chance to ask questions about the vaccine and my questions were answered to my satisfaction. I understand the benefits and risks of the vaccination. I give permission for a pharmacist to administer the influenza vaccine to me. I agree to stay in the general area for 15 minutes after receiving the vaccine, so that I can be observed for any reaction to the vaccine. I understand that if I have any side effects, I will need to follow up with my doctor at my expense. I hereby release the organization(s) sponsoring this vaccination from any and all liability arising from or in any way connected with this vaccination. Aurora has given me a copy of its Notice of Privacy Practices. I give permission for my vaccine information to be shared with the Wisconsin Immunization Registry.

Medical History

No	Yes	Do you have a history of a serious allergic reaction to any component of the influenza vaccine?
No	Yes	Have you had a serious reaction to a flu shot before?
No	Yes	Have you ever had Guillain-Barre' Syndrome within 6 weeks of a previous flu shot?
No	Yes	Do you have a moderate or severe fever today?
No	Yes	Do you have an allergy to latex? (Fluvirin and Fluad pre-filled svringes may contain latex)

If you answered "YES" to any of the above, a pharmacist will discuss the risks and benefits of vaccination with you.

_____ _____

Signature of person to receive vaccine Signature of Parent/Legal Guardian (if under age 18)

Manufacturer of Vaccine_____ Lot_____ Exp. Date_____

Administered_____ Site R L Date_____

Insurance Information

Medicare number (over 65 years old):_____

Insurance Carrier:_____

ID#:_____

Group ID#:_____

RxBIN#:_____

RxPCN#:_____