

Annual Influenza Vaccine Consent Form-2023/2024

****FOR PATIENTS WHO DO NOT HAVE A SCHEDULED APPOINTMENT****

Section 1: Patient Information (please print and complete every section)

Patient Name (Last)		(First)	(M.I.)	Patient DOB:	
Parent/Guardian Name (Last)		(First)	(M.I.)	Patient Age:	Pinon PCP:
Address			Patient/Guardian phone #		
City	CO	Zip			
Name of medical insurance to be billed: <i>(must be completed even if we have your info on file)</i>			Did you leave a copy for our file? Y / N		

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if you can get the seasonal influenza vaccine. **Please mark YES or NO for each question.**

	YES	NO
1. Does patient have a serious allergy to eggs, chicken or chicken feathers?		
2. Is patient currently ill or have a fever?		
3. Has patient ever had a serious reaction to a previous dose of flu vaccine?		
4. Has patient ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?		

Section 3: Consent

CONSENT FOR VACCINATION:

I have read or have had explained to me the 23/24 Vaccine Information Statement (VIS) for the seasonal influenza vaccine and understand the risks and benefits. A copy of the VIS is provided in each exam room for your review. I have read and understand PFP Financial Policy and agree to all term within. I accept full financial responsibility if not paid/covered by my insurance.

Signature of Patient/Legal Guardian _____ Date: _____

FOR ADMINISTRATIVE USE ONLY

Verified above for pertinent positives: _____

Vaccine	Route	Staff initials		Temp	Lot Number / Exp Manufacturer – Sanofi	Name and Title of Vaccine Administrator
		Date Dose Administered	Vaccine Site (RT/LT) (Arm/Thigh)			
FLUBLOK Pres-Free 18+ ONLY (single dose syringe)	IM	/ /			LOT: _____ EXP: _____	
FLUZONE 6mo-17 years (multi-dose vial)	IM	/ /			LOT: _____ EXP: _____	
FLUZONE Pres-Free 6mo-17 years (single dose syringe)	IM	/ /			LOT: _____ EXP: _____	

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