

**DOUGLAS COUNTY HEALTH DEPARTMENT
INFLUENZA INFORMATION/CONSENT FORM
2012-2013 Season**

CIRCLE

- | | | |
|--|-----|----|
| 1. IS THIS YOUR FIRST FLU SHOT? | YES | NO |
| 2. DO YOU FEEL SICK TODAY OR HAVE A FEVER? | YES | NO |
| 3. HAVE YOU EVER HAD <u>SEVERE</u> REACTION TO THE FLU SHOT?
***IF YES, PLEASE EXPLAIN: _____ | YES | NO |
| 4. HAVE YOU EVER HAD GULLAIN BARRE' SYNDROME WITHIN 6 WEEKS OF A PREVIOUS INFLUENZA IMMUNIZATION ?
(This affects the central nervous system as an ascending/ <u>upwardly</u> moving paralysis.) | YES | NO |
| 5. ARE YOU ABLE TO EAT LIGHTLY COOKED EGGS (I.E. <i>SCRAMBLED</i>) WITHOUT AN ALLERGIC REACTION? | YES | NO |
| 6. HAVE YOU EVER HAD A REACTION TO LATEX? | YES | NO |
| 7. DO YOU HAVE A BLOOD CLOTTING DISORDER AND/OR TAKE ANTICOAGULANT MEDICATION WHICH MAY RESULT IN INCREASED BRUISING? | YES | NO |

I have read or have had explained to me the information on this form about influenza and influenza vaccine. I have been provided w/the Vaccine Information Statement for Inactivated Influenza Vaccine 2012-2013 and had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine, including side effects, and request the vaccine be given to me.

PLEASE WRITE LEGIBLY!!!

X

LAST NAME (Please Print <u>ABOVE</u>)	FIRST	MI	DATE OF BIRTH
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ADDRESS (ABOVE)

SIGNATURE (<u>ABOVE</u>)	DATE
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(PLEASE CIRCLE)	DCHD	DOUGLAS COUNTY
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VACCINE: FLULAVAL (GSK)

Lot#: AFLLA727AB

Exp: 6/2013

DOSE: 0.5ml ROUTE: Intramuscular

SITE: (Please circle) Right Deltoid Left Deltoid

SCREENED BY: _____

ADMINISTERED BY: _____ DATE: _____