Indian Health Service
Santa Fe Service Unit
2022-2023 Consent for Seasonal Influenza Vaccination

Last name: __________________________ First name: _________________________ Phone number: _______________

Street Address: ____________________________ City: ______________________ Chart number: ________________

Male ☐ Female ☐ Date of Birth: Month _______ Day _______ Year _______ Age: _______

Emergency contact Name and phone____

Are you feeling ill today? Do you have a fever today?	No ☐	Yes ☐	if yes, please explain below
Have you ever had an allergic reaction to a vaccine?	No ☐	Yes ☐	if yes, please explain below
Are you allergic to: chicken, eggs or egg products	No ☐	Yes ☐	If yes, please explain below
Thimerosal - in vaccines and contact lens solution	No ☐	Yes ☐	If yes, please explain below
Gentamicin	No ☐	Yes ☐	If yes, please explain below
Do you have a bleeding disorder?	No ☐	Yes ☐	if yes, please explain below
Are you taking any medication that could affect blood clotting?	No ☐	Yes ☐	if yes, please explain below
Have you ever been diagnosed with Guillain-Barre Syndrome within 6 weeks of receiving a flu vaccine?	No ☐	Yes ☐	if yes, please explain below
Are you or could you be pregnant?	No ☐	Yes ☐	
I understand the implications of the vaccine and its possible side effects and assume the risks associated with the vaccine	No ☐	Yes ☐	

I have read (or it has been read to me) and I understand the "Seasonal Influenza Vaccine Information Sheet". I have had the opportunity to ask questions and to have them answered to my satisfaction. I consent to the seasonal influenza vaccine. I understand that my health information is confidential, and that State and Federal laws restrict its use and disclosure.

If signing for someone other than yourself, indicate your relationship to that other person: ______________________

If signing for someone other than myself, I confirm that I am the parent / legal guardian or substitute decision maker.

Signature**:** ____________________________________ Print Name**:** _________________________________

Date of signature: ________________________________

For Clinic Use Only:

VACCINE	DOSE	LOT NUMBER	EXPIRY DATE	SITE / IM	TIME GIVEN	DATE GIVEN	GIVEN BY
	0.5 ml						

Comments:

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Revised 9/14/2022 MC