MEDXCEL
OCCUPATIONAL MEDICINE & WALK-IN CLINIC
121 Tivoli Street; Abbeville, LA 70510
Phone: 337-893-0788 Fax: 337-893-0787

# INFLUENZA VACCINE CONSENT

Last Name:________________________________ First Name: ______________________________ MI: _____________

Address: __________________________________ City: _____________________ State: ___________ Zip:___________

Phone #: __________________________________ DOB: _____________________ SSN: __________________________

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED:

Are you allergic to eggs? >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>> YES or NO

Are you pregnant? >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>> YES or NO

Do you have a chronic illness? >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>> YES or NO

Do you have a fever? >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>> YES or NO

Do you have HIV/AIDS? >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>> YES or NO

Are you taking chemotherapy treatments? >>>>>>>>>>>>>>>>>>>>>>>>>>>>> YES or NO

Hypersensitivity reaction may occur following vaccination. The most frequent side effect is soreness at the vaccination site for up to two days. Also, there may be fever and malaise (a general feeling of being unwell). If this occurs, you may take two Tylenol tablets.

I have read and understand the information on this form about the influenza vaccine. I understand the benefits and risks of the influenza vaccine and request that the vaccine be administered to me.

_____________________________________________ ______________________________

Signature Date

FOR OFFICE USE

Site of injection: ___________________ Date: ____________________ Manufacturer: _______________________

Lot #: _________________________ Expiration Date: ___________________ Administered by: _______________