Navajo Health Foundation
SAGE MEMORIAL HOSPITAL
POST OFFICE BOX 457 | GANADO, ARIZONA 86505 | PH (928) 755-4500 | FAX (928) 755-4659

REV. 08/2021

Date Vaccine Given:	Time Vaccine Given:

2021-2022 SEASONAL INFLUENZA VACCINE CONSENT FORM

INSTRUCTIONS: Complete all highlighted areas.

Name:	Date of Birth:	Chart#:
Chief Complaint: Influenza Vaccination	Vital Signs	
MEDICATION ☐ NO **ALLERGIES:** ☐ **YES – *LIST HERE:***		

IS THE PERSON RECEIVING THE INFLUENZA VACCINE…

..Pregnant?	YES or NO
..Have asthma?	YES or NO
..Received a flu shot this season (***between September 1, 2021 to June 30, 2022***)?	YES or NO
..Allergic to eggs?	YES or NO
..Have a fever or severely ill?	YES or NO
..Have a history of GBS (Guillain-Barre-Syndrome)?	YES or NO
..Had any prior allergy to or reaction to the influenza vaccination in the past?	YES or NO
..Received any blood, blood products, immune (gamma) globulin, or antiviral medication in the **past year**?	YES or NO
..Taken medications that affect the immune system, have an immune system problem, or had a transplant, in **the past 3 months**?	YES or NO
Is this **the first time** this patient has received the Influenza Vaccine?	YES or NO

"I have received and read the seasonal Influenza vaccine information statement (VIS). The information has been explained to my understanding. I have had a chance to ask questions and was provided answers to my satisfaction. I understand the benefits and risks of the seasonal Influenza vaccine. I ask that the Influenza vaccine be given to me ***or given to the person named above for whom I am authorized to make this request***."
****NOTE****: By signing this consent for a **minor patient**, you are verifying that you have legal authorization to consent for treatment provided to the minor patient named above.

CONSENT SIGNATURE: **RELATIONSHIP TO PATIENT:**

FOR SAGE PERSONNEL USE ONLY

2021 – 2022 INFLUENZA VACCINE ADMINISTERED

VACCINE LOT#:		MANUFACTURER:		EXPIRATION DATE:	

	√	*INITIALS*		√	*INITIALS*	
LOCATION:			**Right** DELTOID IM 0.5ML Given			**Left** DELTOID IM 0.5ML Given
LOCATION:			**0.25ML** GIVEN **Site**:_____ (***6 months to 35 months***)			0.5ML IM Given; **Site**:_____

SIGNATURES

PROVIDER SIGNATURE:		DATE:
NURSE/MA SIGNATURE:		DATE: