Western Sierra Medical Clinic
Better Health Together

Influenza Consent Form – Adult (2021-2022)

www.wsmcmed.org

Patient Name: _____ DOB: _____

Please complete the checklist below so you can safely receive an appropriate influenza vaccine injection.

	Yes	No	Don't Know
Have you been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine:_____ Date given: _____			
Do you have a long-term health problem with heart disease, lung disease, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., Diabetes), or anemia or another blood disorder?			
Are you on a long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day?)			
Do you have cancer, leukemia, HIV/Aids, or any other immune system problem, or, in the past 3 months, taken medications that weaken the immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?			
Are you pregnant or could become pregnant within the next month?			
Do you live with, or expect to have close contact with, a person whose immune system is severely compromised and who must be in protective isolation?			
Are you patient receiving antiviral medications?			
Are you feeling sick today?			
Did you have the flu vaccine before?			
Did you have a reaction to any vaccine in the past?			
Are you allergic to egg, egg products, chickens, feathers or thimerosal?			
Do you have any allergies? Please list:			
Have you ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness)?			

I have read, or have had explained to me, the applicable Vaccine Information Sheet from the Centers for Disease Control and Prevention explaining the risks and benefits of the vaccine that will be administered. I have had a chance to ask questions which were answered to my satisfaction. I hereby consent to the staff of Western Sierra Medical Clinic administering an influenza vaccine to me containing the strains recommended by the Centers for Disease Control and Prevention (www.cdc.gov/flu/season/faq-flu-season-2021-2022).

Patient Signature: _____ Date: _____

The following to be completed by Western Sierra Medical Clinic

Patient Name:	**DOB:**		
Western Sierra Medical Clinic	**Date Vaccinated:**	**Injection given by:**	
Lot:	**Exp:**	**Site:**	
☐ **Private Insurance**	☐ **Medi-Cal**	☐ **Self-pay**	☐ **Other**