



# MDA 36 (Cromwell, Durham, Middlefield, Middletown Health Departments)

## Seasonal Flu Vaccination Participant Consent Form

Insurance Carrier: \_\_\_\_\_ ID # \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender:    Male            Female            Phone: \_\_\_\_\_

Email: \_\_\_\_\_

### Flu Shot Information

- 1. Have you had a flu shot before?                     Yes     No
- 2. Do you feel sick or have a fever?                     Yes     No
- 3. Have you ever had a serious reaction to a flu vaccine?                     Yes     No
- 4. Are you currently taking an antibiotic for an infection?                     Yes     No
- 5. If you are female, are you pregnant?                     Yes     No

I hereby certify that the foregoing history is true and complete to the best of my knowledge. I understand the benefits and risks of influenza vaccine, and ask that the vaccine be given to me. I will not hold MDA 36, Protein Sciences, its partners, and or any employees responsible for any errors or omissions that I may have made in completing this form.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

### FOR CLINIC USE ONLY

Brand Name & Lot #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Date Vaccinated: \_\_\_\_\_

Site of Injection:     Left Deltoid     Right Deltoid

Clinic Location: \_\_\_\_\_

Signature and title of vaccine administrator: \_\_\_\_\_