UCLA Health

MRN:
Patient Name:

(Patient Label)

# INFLUENZA CONSENT FORM, INACTIVATED AMBULATORY CLINIC

**Patient Name:**_____

**DOB:**_____ **MRN:**_____

**Name of Person Signing:**_____

**Inactivated Influenza Vaccine**
**Do you have any of the following conditions? (check all that apply):**

☐ Severe reaction to an Influenza vaccination in the past
☐ Severe reaction to any vaccine component
☐ Fever ≥ 99.5 °F accompanied by moderate to severe illness (wait until you are recovered to get vaccinated)

**IF YOU CHECKED "YES" TO ANY OF THE ABOVE YOU MAY NOT RECEIVE THE VACCINE**.

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**If Any Of The Above Are Checked We Will Inform Your Physician Prior To You Receiving The Vaccine**.

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**Influenza Consent**
I consent to the Flu vaccination. I have read and understood the CDC "Vaccine Information Statement: *What you need to know*": "Inactivated Influenza Vaccine". I have had the information about the Influenza vaccine explained to me and I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of Influenza (FLU) vaccine and request that the vaccine be given to me.

I have not been administered the Flu vaccine for this flu season.

Patient or Representative Signature _____ Date_____Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Signature _____ Date_____Time _____

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