



Community Influenza Consent Inactivated Injectable 2021/2022

* Required

<p>Information about person to be vaccinated (please print)</p> <p>*Last Name: _____</p> <p>*First Name: _____ *Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>*Date of Birth: _____</p> <p>Address: _____</p> <p>City/State: _____ Zip: _____</p> <p>Phone Number: _____</p>	<p>For office use only</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Has the person ever been to a Monument Health facility? Yes No

*Please answer the following questions for the person being vaccinated.	Yes	No	Don't Know
1. Is the person sick today?			
2. Does the person have an allergy to eggs or to a component of influenza vaccine?			
3. Has the person ever had a serious reaction to influenza vaccine in the past?			
4. Has the person ever had Guillain-Barre` Syndrome?			

Please indicate vaccine to be given.

- Standard Dose Influenza Vaccine
- High Dose Quadrivalent Vaccine (indicated for 65 years old and older)

I have been provided a copy of and have read or have had explained to me the information about influenza and the vaccine listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I understand and I consent that information about my vaccinations will be shared with the South Dakota Department of Health who maintains a database of vaccinations.

*Signature: _____ *Date: _____ *Time: _____

For Office Use Only:

	Type	Vaccine Manufacturer	Vaccine Lot Number	Vaccine Expiration Date	
INFLUENZA	<input type="checkbox"/> IIV4 - Inactivated Influenza Vaccine, Quadrivalent	<input type="checkbox"/> GSK	<input type="checkbox"/> 3A7CG	<input type="checkbox"/> 6/30/22	
	<input type="checkbox"/> High Dose Quadrivalent	<input type="checkbox"/> Seqirus	<input type="checkbox"/> 312846	<input type="checkbox"/> 5/24/22	
	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	
	Route	VIS Publication	Date/Time	Site	Signature of Person Administering Vaccine
	Intramuscular	08/06/2021		<input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid <input type="checkbox"/> _____	