Resurrection Medical Center

7435 W. Talcott Ave, Chicago, IL 60631, Community Health Education

INFLUENZA VACCINE ACKNOWLEDGEMENT/CONSENT FORM

RECIPIENT INFORMATION *(Please Print Clearly)*

Last Name: _____ First Name: _____ Age: _____ Date of Birth (MM/DD/YYYY): _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Gender: ☐ Male ☐ Female ☐ Other Language Spoken at Home: _____

Ethnicity: ☐ Hispanic or Latino ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other: _____ ☐ Not-Hispanic or Latino

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other: _____

IF YOU REQUEST THE INFLUENZA VACCINE, ANSWER QUESTIONS 1-4 & SIGN

PLEASE READ: The following questions help us to determine if there is any reason we should not give you inactivated injectable influenza vaccination today. If you answer "yes" to any questions, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. You have been informed and understand the benefits and risks of the influenza vaccine. You have been given the Influenza Vaccination Information Statement (VIS) dated 1/31/2025.

1. Are you moderately or severely sick today? ☐ Yes ☐ No
2. Have you ever had a serious, life-threatening reaction to an influenza vaccine in the past?
   Brand, if known: _____ ☐ Yes ☐ No
3. Do you have any serious, life-threatening allergies?
   If yes, please list: _____ ☐ Yes ☐ No
4. Have you ever had Guillain-Barré syndrome (a disorder that affects the nervous system) within 6 weeks of receiving an influenza vaccine? ☐ Yes ☐ No

By signing this form, you are indicating that:

- The Clinician has discussed vaccines and explained the risks and benefits.
- I have been offered a copy of the Vaccine Information Statement(s) (VIS).
- I have read, had explained to me, and understand the information in the VIS(s)/fact sheet(s).

I consent to the influenza vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

Signature: _____ **Date**: _____ **Time**: _____ **am** **pm**
(patient/parent/legal authorized representative)

If signed by other than patient, indicate name and relationship: _____

FOR OFFICE USE ONLY: Affix vaccine label sticker, if available

Fluarix Trivalent PFS 0.5 mL IM	MFR: GlaxoSmithKline	Lot #: _____ Exp: _____
FluLaval Trivalent PFS 0.5 mL IM	MFR: GlaxoSmithKline	Lot #: _____ Exp: _____
Other: _____	MFR: _____	Lot #: _____ Exp: _____
Fluad Trivalent Adjuvanted PFS 0.5 mL IM (65 years and older) (dependent on which vaccines pharmacy receives)	MFR: Seqirus Inc.	Lot #: _____ Exp: _____
Other: _____	MFR: _____	Lot #: _____ Exp: _____

Site: ☐ Left Deltoid ☐ Right Deltoid

_____ _____ _____
Administered by (PRINT NAME & Credentials) Signature/title Date Administered

1 VC

PATIENT ID

INFLUENZA VACCINE ACKNOWLEDGEMENT/CONSENT
PHSI-100-415 RMIL (10/25)