

2024-2025  
**INFLUENZA VACCINE  
CONSENT FORM**

Occ Med at MCCH  
204 S. 9<sup>th</sup> Street  
Murray, Ky 42071

Influenza is a virus that causes a severe form of respiratory tract infection with generalized bodily symptoms. It spreads around the world in epidemics and is responsible for much illness as well as many deaths. The vaccine offered this season is a vaccine that is recommended by the World Health Organization (WHO) for the strains of the flu virus that they expect to be circulating this year. The effectiveness of the vaccine is short lived and revaccination should occur on an annual basis to insure protection.

**I have read the above statement and the Vaccine Information Statement (VIS) for Influenza Vaccine (Inactivated and Recombinant) (publication date 8/6/2021) and have had an opportunity to ask questions regarding the use of flu vaccine. I attest that the following statements are true:**

- **I have not had a previous severe reaction to any flu vaccine**
- **I have never had Guillain-Barre syndrome**
- **I am not currently “ill”, experiencing a fever or have tested positive for COVID-19**

**I would like to request the administration of this vaccine:**

Print Name Clearly: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) - \_\_\_\_\_ SSN: \_\_\_\_\_ Not required  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Staff Use Only

Do not administer the Flu Vaccine if the employee answers yes to any of the following:

- A previous severe reaction to any flu vaccine
- Diagnosed with Guillain-Barre syndrome
- Are currently “ill”, experiencing a fever or Positive for COVID-19

**Attach Syringe Label Here:**

Vaccine Administered: \_\_\_ Right Deltoid \_\_\_ Left Deltoid Other: \_\_\_\_\_

Administered by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

*Vaccine Information Statement, for Influenza Vaccine (Inactivated and Recombinant) dated 8/6/2021, provided at the time of vaccine administration.*