

Adult Flu Record & Consent Form

Fill in Information About Person to Receive Vaccine (Please Print)

Last Name	First Name	Middle Name
Parent or caregiver of a UPMC CCP patient		
Relationship		
Home Mailing Address		
City	State	Zip
Date of Birth (mm/dd/yyyy)	Phone Number	Email Address

Are you sick today?	☐ Yes	☐ No
Do you have an allergy to an ingredient of the vaccine?	☐ Yes	☐ No
Have you ever had a serious reaction to influenza vaccine in the past?	☐ Yes	☐ No
Do you have a history of Guillain-Barre Syndrome (a severe paralytic illness)?	☐ YES	☐ NO
Have you ever felt dizzy or faint before, during, or after a shot?	☐ YES	☐ NO
Do you feel anxious about getting a shot today?	☐ YES	☐ NO

I hereby certify that the foregoing information is true and complete to the best of my knowledge. I further hereby acknowledge having been given the **"Vaccine Information Statement (VIS): Inactivated Influenza Vaccine: WHAT YOU NEED TO KNOW"** and have had an opportunity to read the information contained on the form. I have had a full opportunity to ask questions, and my questions have been answered. Understanding the benefits and risks involved, I consent to have the vaccine given to me. BY DOING SO, I HEREBY VOLUNTARILY RELEASE AND FOREVER DISCHARGE, FOR MYSELF AND MY HEIRS, EXECUTORS, AND/OR ADMINISTRATORS, CHILDREN'S COMMUNITY PEDIATRICS AND UPMC FROM ANY AND ALL CLAIMS, DEMANDS, ACTIONS, AND CAUSES OF ACTION, WHICH MAY RESULT FROM RECEIVING THIS VACCINATION.

Signature _____ Date _____

For Clinic Use Only:	
Signature of Vaccine Administrator	Vaccination Date: _____ VIS Publication Date: <u>1/31/2025</u> Injection Site: _____ Dosage Volume: <u>0.5mL</u> Route: <u>IM</u>
Signature Date: _____	Vaccine: Flucelvax Manufacturer: <u>Seqirus</u> Lot Number: _____ Expiration Date: _____

This form must be signed and presented at the time of vaccination.

Please consult your primary medical provider if you any questions, concerns, or reactions after receiving a flu vaccine.