



## Influenza Vaccine Consent Form

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Consent

I have been offered the current influenza vaccine information sheet (VIS). I have been provided education and given an opportunity to ask questions about the disease and vaccination. I understand the risks and benefits of the vaccination. I understand that the vaccination I am to receive is a single shot for adults and for children who have received a flu vaccine in previous years. Children, age 7 years and younger, receiving their first dose of influenza vaccine require a second dose in that same season.

I understand that it will not be fully effective for approximately two weeks. However, with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I understand that one should not receive the vaccine if they have a severe allergy to eggs, have had a severe reaction to a previous influenza vaccine, or if they have had Guillain-Barre Syndrome. I hereby request the influenza vaccine for the 2025-2026 flu season be given to myself or the person for whom I am authorized to give consent.

I authorize the Effingham County Health Department to bill my Insurance for the vaccine and administration.

I also consent to have my immunization data entered into the State of Illinois Electronic medical Record system called I-Care.

Patient or Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed/Administered By: \_\_\_\_\_ Date: \_\_\_\_\_

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### CLINIC/OFFICE USE ONLY

Vaccine: Expiration Date: 06/30/2027 Lot #: \_\_\_\_\_

Site: Right Left Deltoid Thigh

Eligibility: 317 Private VFC

Nurse: KEnloe DLueken BMiller LOhnesorge MSporleder Other \_\_\_\_\_

EZ Encounter \_\_\_\_\_ EZ Charted \_\_\_\_\_ IC Check \_\_\_\_\_ Scanned \_\_\_\_\_