



Influenza Consent Form

This voucher permits the individual named below to receive influenza vaccine

BRING THIS VOUCHER WITH YOU

Vaccine: Seasonal Influenza

Demographic Information

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Birth: _____

Age: _____ Sex: M ☐ or F ☐

Health History Information (Please check answer)

- | | |
|--|--|
| 1. Has this person had a serious reaction to vaccine in the past? | ☐ Yes ☐ No |
| 1a. Person had cardiac arrest, collapsed or called 911 after getting vaccine? | ☐ Yes ☐ No |
| 2. Does this person have an allergy to eggs or egg products? | ☐ Yes ☐ No |
| 2a. Has this person had a reaction to eggs involving symptoms other than hives, such as angioedema, respiratory distress, lightheadedness, or recurrent emesis; or who required epinephrine or another emergency medical intervention? | ☐ Yes ☐ No |
| 3. Has this person ever had Guillain-Barre Syndrome (GBS)? | ☐ Yes ☐ No |
| 3a. Person had a history of GBS within six weeks after having flu vaccination? | ☐ Yes ☐ No |
| 4. Is this Person allergic to Thimerosal or mercury products? | ☐ Yes ☐ No |
| 4a. Person experienced respiratory distress or collapsed using Thimerosal products? | ☐ Yes ☐ No |
| 5. Is this Person currently having any signs or symptoms of COVID-19? | ☐ Yes ☐ No |
| 5a. Has this person been advised by a healthcare provider that you are a suspect case of COVID-19, regardless of signs or symptoms? | ☐ Yes ☐ No |

I, the undersigned, certify that all the above information is correct to the best of my knowledge. I hereby authorize the recipient of this document to share this information with public health entities at the local, state and federal level for purposes of ensuring medication efficacy and safety. I have been offered a Notice of Thomas County Health Department Privacy Practices effective 1/1/2023.

Client Signature: _____

Date: _____

Clinician Use Only:

Vaccine Provided: ☐ IM

Location: ☐ R ☐ L ☐ Deltoid ☐ VL

Clinic Site: _____

Vaccinator's Signature: _____

Date: _____

Lot Numbers

Private: **418655 Exp: 6/25/2027**

VFC/Chip: **24JY5 Exp: 6/30/2027**

317: **24JY5 Exp: 6/30/2027**

High Dose: **418594 Exp: 5/9/2027**

Vaccine Information Statements

VIS Date: 01/31/2025

WebIZ: _____ Scanned: _____ Billed: _____

STAFF USE ONLY

Cash/Credit/Check # _____

Contract Pay: _____

Insurance: _____

KanCare Title 19: ☐ Title 21: ☐

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Visit our website at: www.thomascohealth.com

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