Influenza Vaccination Consent Form & Record (2025-2026)

Must be at least 5 years old to receive vaccine in pharmacy
Please remain in pharmacy for 10 minutes after injection

Aston Pharmacy
Home Health Center
"Where caring is the heart of our business"

PERSONAL INFORMATION:	
01/31/25 Vaccine Information Statement Please scan and read Paper copies available upon request	**PATIENT NAME:** **DATE OF BIRTH:** **PHONE:** **ADDRESS:** **Allergies/Medical Alerts:** **Primary Physician:** **Office Location:**

Please circle Yes or No to each question below:

1 – 1.A HIGH DOSE VACCINE QUESTIONS ONLY		
1. <u>Are you 65 years or older?</u> If NO, skip to Q 2	Yes	No
1.a. Do you prefer to receive the HIGH DOSE vaccine if available? CDC has no opinion. If no, skip to Q 2. If yes, please answer the following HIGH DOSE question.	Yes	No
1.b. Are you severely allergic to eggs, egg proteins, thimerosal, neomycin, kanamycin, hydrocortisone formaldehyde or any component of the flu vaccine? *If yes, avoid HIGH DOSE.	Yes	No
2. If you are < 18 years old, is your parent or guardian present or available by phone to get consent?	Yes	No
3. Are you currently sick with a fever, vomiting or diarrhea?	Yes	No
4. Have you ever had a serious reaction to an influenza vaccine?	Yes	No
5. Have you ever had Guillain-Barŕe syndrome?	Yes	No
6. Are you Latex allergic?	Yes	No
7. Do you have an immune-compromising condition (e.g. cancer, leukemia, lymphoma, HIV/ AIDS, transplant) functional or anatomic asplenia, CSF leak or cochlear implant or take a medication (e.g. steroids or chemotherapy) that lowers the body's resistance to infection?	Yes	No
8. Have you ever fainted or felt dizzy before, during or after a vaccination?	Yes	No
9. Do you have a bleeding disorder or are you on a blood thinner?	Yes	No
10. Females Only: Are you pregnant or nursing?	Yes	No

Note: If you answered YES to Q 1.B you should <u>NOT</u> receive a <u>HIGH DOSE</u> influenza vaccine.
If you answered YES to Q 3 - 5 you should <u>NOT</u> receive an influenza vaccine.

I have received, read or had the CDC Vaccine Information Statement (VIS) explained to me. I currently have no further questions. I understand the risks and benefits of the vaccine and consent to emergency treatment if needed. I request and voluntarily consent to receive the influenza vaccine, and I acknowledge that no guarantee has been made concerning the vaccine's success. I authorize the release of medical or other information necessary to process insurance claims or for public health purposes.

Patient or Guardian Signature: _____ **Date:** _____

Printed name of above: _____

For Clinic Use Only

Vaccine 2025-2026	Manufacturer	VIS Date	Lot #	Exp Date	Site/Route	Dosage Vol
☐ Flucelvax Trivalent	Seqirus, Inc	01/31/25			LD RD IM	0.5 mL pfs
☐ Fluad Trivalent **HIGH DOSE**	Seqirus Inc	01/31/25			LD RD IM	0.5mL pfs

Signature of Vaccine Administrator: _____ **Administration Date:** _____

For office use only: _____Billed _____Scanned _____PIERS _____Faxed Doctor 09292025