



SVT
Health & Wellness
A branch of Seldovia Village Tribe

*Partnering in
the Journey!*

Consent for Influenza Vaccination

Patient Name: _____ Date of Birth: ____/____/____

Address: _____

City, State, Zip: _____ Phone Number _____

Circle One: (White) (Black or African American) (Asian) (American Indian/AK Native) (Other) (Multi) (Unknown)

Medicare Medicaid Uninsured Other Insurance _____ IHS

- I have received the Vaccine Information Statement (VIS) and have had a chance to ask questions and those questions were answered to my satisfaction. I believe I understand the benefits and risks of this vaccine and request the vaccine(s) be given to me, or to the above-named patient for whom I am authorized to make this request.
- I have been instructed that as a result of this vaccination I/patient may experience some side effects such as, but not limited to, the following:
 - Slight discomfort and/or bruising at the injection site
 - Muscle aches
 - Soreness of the arm
 - Joint aches and/or Weakness
 - Redness of the arm
 - Rash and/or Itching
 - Blushing and/or Tingling
 - Slight fever and/or Chills

Please answer the following questions:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Is the person to be vaccinated sick today? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Does the person to be vaccinated have an allergy to a component of the vaccine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Has the person to be vaccinated ever had Guillain-Barre Syndrome? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

- If I am a patient of SVTHW I authorize that this vaccination be put in my chart.

Immunization Administered by: SVT Health & Wellness, 880 E End Rd, Homer, AK 99603.

Patient/Parent/Guardian Signature

Date

If signed by Parent/Guardian, PRINT NAME

Office Use:

Administered By

- IM R Deltoid
 IM L Deltoid

Printed Name