

# Lincoln Medical Partners

MaineHealth

## INACTIVATED INFLUENZA VACCINE (injection) CONSENT & ADMINISTRATION 2023-24

Name (please print): \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Phone Number \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Employer or School: \_\_\_\_\_

MaineHealth Employee or Volunteer:  Yes  No

### Insurance Information

Guarantor's Name: \_\_\_\_\_ Guarantor's DOB: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Insurance Effective Date: \_\_\_\_\_

ID/Certificate #: \_\_\_\_\_ Group #: \_\_\_\_\_

### For adult patients as well as parents of children to be vaccinated:

The following questions will help us to determine if there is any reason you should not receive a flu shot today. If you answer 'yes' to any question, it does not necessarily mean you, or your child, should not be vaccinated. It may mean that additional questions may be asked. If a question below is not clear, please ask your healthcare provider to explain.

### Please answer the following questions:

1. Serious prior allergic reaction to influenza vaccine  Yes  No
2. Serious allergy to eggs/egg products\*  Yes  No
3. Serious allergy to gentamicin (Fluarix® only)  Yes  No
4. Serious allergy to thimerosal (Offices with multi-dose vial only)  Yes  No
5. History of Guillian-Barre Syndrome  Yes  No
6. Fever or feeling ill today  Yes  No
7. Bone marrow or organ transplant in past 4 month  Yes  No
8. Receiving chemotherapy, biotherapy, or radiation therapy (scheduled to start in the next 2 weeks, currently receiving, or received within the last 3 months)  Yes  No

\* Note: Patients with serious allergy (e.g. anaphylaxis) to eggs/egg products may still receive influenza vaccine per CDC/ACIP. If the patient has a history of anaphylaxis with eggs, they should remain in the office for 15 minutes after receiving the influenza vaccine to monitor for reaction.

Signature for Consent: \_\_\_\_\_ Date: \_\_\_\_\_

### For Office Use Only:

Vaccine Manufacturer	Vaccine Lot Number	Vaccine Expiration	0.5mL IM		VIS given?	Administered by (print name)	Date
Adult: GSK		06/30/2024	LD	RD	Circle Y if YES		
Adult HD: Sanofi		06/30/2024	LVL	RVL	Y		
Pedi: Sanofi							

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