

GMS

ANNUAL FLU VACCINE CONSENT FORM

NAME _____

ADDRESS _____

PHONE NUMBER _____

BIRTHDATE _____

INSURANCE PROVIDER _____ ID# _____

*Please provide copy of pharmacy insurance card if possible

SCREENING QUESTIONS:

1. Are you sick today? Y / N
2. Do you have an allergy to eggs or to another component of flu vaccines? Y / N
3. Have you every had a serious reaction to a flu vaccine in the past? Y / N
4. Have you ever had Guillain-Barre syndrome? Y / N
5. Are you pregnant? Y / N
6. Have you had a mastectomy? Y / N

CONSENT AND SIGNAUTRE

I give consent to *Sav-Mor Drug and Gifts* and its staff to vaccinate me with this vaccine.

Signature _____ Date _____

VACCINATION RECORD

Vaccine: _____

Route: IM - R / L Lot: _____ Exp: _____

Vaccine Administrator: _____