CONSENT FOR INFLUENZA IMMUNIZATION 2021

PATIENT INFORMATION	
First Name:	Last Name:
Date of Birth:	Age:
Family Doctor: ☐Dr. Galloway **OR** ☐Dr. Olsen	Version Code: *(Two letters at the end of your health card #)*

SCREENING QUESTIONNAIRE FOR PATIENT TO BE VACCINATED

Do you have any of these symptoms of COVID-19? *(check any/all that apply)*

☐ New or worsening cough	☐ Headaches	☐ Sudden loss of smell
☐ Shortness of breath	☐ Fever	☐ Sudden loss of taste
☐ Congestion	☐ Muscle pains	☐ Extreme fatigue
☐ Sore throat	☐ Any new abdominal complaints (nausea, vomiting, diarrhea, pain)	

Please confirm the following:

☐ I do not have a history of adverse reactions to any vaccines

☐ I am currently not experiencing an active recurrence of Multiple Sclerosis

☐ I have never had Guillain-Barre Syndrome (a rare condition that causes paralysis)

PATIENT/AGENT CONSENT

I, the undersigned patient or agent (parent or guardian), have read this form and had the opportunity to ask questions and answers were given to my satisfaction. I understand the risks, benefits, expected outcome, and possible side effects of this vaccine and agree to stay on the premises for 15 minutes after receiving the vaccination.

☐ I confirm that I want to receive the flu shot **OR** ☐ I confirm that I want my child to receive the flu shot

Patient/Agent Name (& Relationship)	Patient/Agent Signature	Date (mm/dd/yyyy)