



2025-2026 INFLUENZA VACCINE ADMINISTRATION CONSENT

Patient: _____ Birth Date: _____

I have read/viewed the Influenza Information Statement (VIS) provided by the CDC, dated 8/6/2021 and consent to the administration of the Flu Vaccine. I understand the possible side effects that may occur with this vaccine.

Have you had a serious allergic reaction to eggs or previous flu vaccine? ☐ YES ☐ NO

Are you sick today? ☐ YES ☐ NO

Have you had an attack of Guillain-Barre Syndrome (GBS)? ☐ YES ☐ NO

To the best of my knowledge, I have provided Lifespan Family Healthcare with all the pertinent health information necessary.

Patient/Parent Signature

Date
