PIONEER
PHYSICIANS NETWORK

Influenza Vaccine 2024-2025
Patient Permission to Receive Injection

Patient Name _____ Phone # _____

Date of Birth _____ Date _____

Physician's Name _____ Insurance(s)_____

Please answer the following questions:		Circle One	
1.	Do you presently have any cold and/or flu symptoms?	Y	N
2.	Have you had a serious reaction to the flu vaccine?	Y	N
3.	Do you have a history of Guillain-Barre' Syndrome?	Y	N
4.	Do you have an acute respiratory or other active infection or illness?	Y	N
5.	Do you have an **active** Neurological Disorder?	Y	N
6.	Do you presently have a fever over 100 degrees?	Y	N

If you have answered YES to any of the above questions, consult a physician prior to receiving the flu vaccine.

Education: ☐ Discussed possible side effects ☐ Provided health education materials

I have read the attached information about the influenza and influenza vaccine, and I have had a chance to ask questions. I understand the benefits and risks of influenza vaccination and request that the vaccine be given to ☐ me or ☐ the person named above for whom I am authorized to sign.

Patient Signature_____Date_____

OFFICE USE ONLY

Patient Received (please circle): Flucelvax Quadrivalent Fluad Quadrivalent

Manufacturer: Seqirus Inc.
Lot #: _____
Exp Date: _____

MA/Nurse Initials: _____

Dose
☐ 0.50 ml

Site
☐ RT Deltoid IM
☐ LT Deltoid IM
☐ RT Thigh IM
☐ LT Thigh IM