Ely-Bloomenson Community Hospital

328 West Conan Street
Ely, MN 55731
218-365-3271 | www.ebch.org

CONSENT FORM FOR INFLUENZA SHOT (ADULT)

PLEASE PRINT CLEARLY

LAST NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

PHONE NUMBER: _____DATE OF BIRTH: _____

CONSENT FOR VACCINATION: I have read or had explained to me the 2020-2021 vaccine information statement for the seasonal influenza vaccine and understand the risks and benefits and have been allowed to ask questions, and answers were given to my satisfaction. **I GIVE CONSENT** to Ely-Bloomenson Community Hospital and its staff to be vaccinated with this vaccine. My signature serves as verification that I have the legal authority to sign.

SIGNATURE: _____ DATE: _____

PLEASE NOTE: To monitor influenza immunization levels among community members and health care workers in this facility and across the state, the flu vaccination you receive or provide information for today will be recorded in MIIC (the Minnesota Immunization Information Connection, the statewide registry). Information in MIIC is confidential and will only be shared with organizations or persons authorized by law to receive it. If you do not want to participate in the registry, please call 1-800-657-3970.

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

For Patients to be vaccinated: the following questions will help us determine if there is any reason, we should not give you inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. If means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	YES	NO	UNSURE
1. Is the person to be vaccinated sick today?			
2. Does the person to be vaccinated have an allergy to a component of the vaccine?			
3. Has the person to be vaccinated ever had a severe reaction to the influenza vaccine in the past?			
4. Has the person to be vaccinated ever had Guillain-Barre´ syndrome?			
5. If you are 65 or older, would you like the high dose vaccination today? If yes, please provide your Medicare Insurance Cards to our Registration Staff for verification.			

Name & Title of vaccine administrator: _____

Form Reviewed: NO _____ YES _____

VACCINE	ROUTE	DATE ADMINISTERED	VACCINE MANUFACTURER	LOT NUMBER	EXPIRATION
Fluzone-HD	IM		Sanofi Pasteur		
Fluzone-Quad	IM		Sanofi Pasteur		
Fluzone-Quad	IM		Sanofi Pasteur		