Toledo-Lucas County Health Department
Informed Consent for Influenza Vaccine 2020 - 2021

The Toledo-Lucas County Health Department offers influenza vaccines to individuals based on CDC recommendations. Please review the questions below and answer appropriately. ***PLEASE PRINT:***

Name _____Age_____ Date of Birth _____ Sex: M / F

Street Address_____ Hispanic / Non-Hispanic

City _____ County _____ State _____ Zip code _____

Phone Number: (Home) _____ (Cell) _____ Race: _____

Social Security #: _____ Marital Status (circle): Single Married Divorced

Language if other than English: _____ Translation By: _____

Please answer the following questions by placing a circle around the correct answer:

Is the person to be vaccinated sick today?	Yes	No	Not sure
Does the person to be vaccinated have an allergy to a component of the vaccine?	Yes	No	Not sure
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	Yes	No	Not sure
Has the person to be vaccinated ever had Guillain-Barre Syndrome (GBS). (Paralysis following a viral illness or vaccine)	Yes	No	Not sure

I consent that the nurse or designee from the Toledo-Lucas County Health Department administers the influenza vaccine to the above-named person. I have had adequate opportunity to ask pertinent questions regarding the safety, value and possible side effects of the vaccines I am requesting. I have received relevant Vaccine Information Statements and the Notice of Use of Private Health Information. I will hold the Toledo-Lucas County Health Department and its representatives free from any liabilities that may arise as a result of the vaccine(s) received. If I did not pay with cash or check, I understand and agree that all amounts I may submit to my insurance company that are NOT reimbursed to me (including: denied as non-covered, disallowed amount, maximum payable, preventive medicine, patient co-pay or deductible) are my financial responsibility. Should the Toledo-Lucas County Health Department submit any charges to my insurance on my behalf, I agree to pay the remainder upon receipt of invoice.

_____ _____

Signature of patient or guardian Date

For Health Department Use Only:

QUADRIVALENT - .5 ml	317 - .5 ml	HIGHDOSE - .7ml
GlaxoSmithKline (SKB)	GlaxoSmithKline (SKB)	Sanofi (PMC)
Lot #: Z7275	**Lot #:** 4PA3X	**Lot #:** UJ453AA
Exp. Date: 06/30/2021	**Exp. Date:** 06/30/2021	**Exp. Date:** 06/30/2021

Route of Administration: IM **Site:** R Deltoid / L Deltoid / R Thigh / L Thigh

_____ _____

Signature of Nurse Date VIS: 08/15/2019

For Nurse Use Only:

_____ Patient left clinic in good condition
_____ Patient understood instructions and information
_____ Patient experienced problem or reaction. Elaborate on back of sheet.