



Indian Health Service Santa Fe Service Unit 2025-2026 Consent for Seasonal Influenza Vaccination

Last name: _____ First name: _____ Phone number: _____

Street Address: _____ City: _____ Chart number: _____

Male ☐ Female ☐ Date of Birth: Month _____ Day _____ Year _____ Age: _____

Emergency contact Name and phone _____

Are you feeling ill today? Do you have a fever today? No ☐ Yes ☐ if yes, please explain below

Have you ever had an allergic reaction to a vaccine? No ☐ Yes ☐ if yes, please explain below

Are you allergic to: chicken, eggs or egg products No ☐ Yes ☐ If yes, please explain below
Thimerosal - in vaccines and contact lens solution No ☐ Yes ☐ If yes, please explain below
Gentamicin No ☐ Yes ☐ If yes, please explain below

Do you have a bleeding disorder? No ☐ Yes ☐ if yes, please explain below

Are you taking any medication that could affect blood clotting? No ☐ Yes ☐ if yes, please explain below

Have you ever been diagnosed with Guillain-Barre Syndrome within 6 weeks of receiving a flu vaccine? No ☐ Yes ☐ if yes, please explain below

Are you or could you be pregnant? No ☐ Yes ☐

I understand the implications of the vaccine and its possible side effects and assume the risks associated with the vaccine No ☐ Yes ☐

I have read (or it has been read to me) and I understand the "Seasonal Influenza Vaccine Information Sheet". I have had the opportunity to ask questions and to have them answered to my satisfaction. I consent to the seasonal influenza vaccine. I understand that my health information is confidential, and that State and Federal laws restrict its use and disclosure.

If signing for someone other than yourself, indicate your relationship to that other person: _____

If signing for someone other than myself, I confirm that I am the parent / legal guardian or substitute decision maker.

Signature: _____ Print Name: _____

Date of signature: _____

For Clinic Use Only:

VACCINE	DOSE	LOT NUMBER	EXPIRY DATE	SITE / IM	TIME GIVEN	DATE GIVEN	GIVEN BY Signature
	0.5 ml						

Print Name (Vaccinator) _____