



Anchorage School District  
Healthcare Services  
**Flu Vaccine Consent for Adults**



**Patient Information**

☐ Check here if 65 and older

|          |        |        |
|----------|--------|--------|
| Last:    | First: | DOB:   |
| Address: |        | Phone: |
| City:    | State: | Zip:   |

**Health Screen**

*The following questions will help us determine if there is any reason we should not give you or your child injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.*

| Questions                                                                                                | Yes                   | No                    |
|----------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|
| Is the person to be vaccinated <b>sick</b> today?                                                        | <input type="radio"/> | <input type="radio"/> |
| Does the person to be vaccinated have an <b>allergy</b> to an ingredient of the vaccine?                 | <input type="radio"/> | <input type="radio"/> |
| Has the person to be vaccinated ever had a <b>serious reaction</b> to the influenza vaccine in the past? | <input type="radio"/> | <input type="radio"/> |
| Has the person to be vaccinated ever had <b>Guillain Barré Syndrome</b> ?                                | <input type="radio"/> | <input type="radio"/> |

**Consent**

*I have read and understood the Vaccine Information Sheet (VIS) and understand the risks and benefits of the flu vaccine, including potential side effects. I consent for myself to receive the flu vaccine administered by the Anchorage School District. I authorize entry of this record into VacTrAK and release the district from liability.*

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**THANKS FOR HELPING KEEP OUR COMMUNITY HEALTHY!**

*For Nurse Use Only to Document Administration*

| Vaccine                                                    | Date Given | Route                                                                 | Vaccine Info                     | Nurse Signature |
|------------------------------------------------------------|------------|-----------------------------------------------------------------------|----------------------------------|-----------------|
| 6mos – 64 y.o.<br>Influenza, split<br>virus, trivalent, PF |            | IM – Deltoid<br><input type="checkbox"/> L <input type="checkbox"/> R | Lot#:<br>Exp. Date:<br>VIS Date: |                 |
| 65+ y.o.<br>Influenza, <b>High-dose</b> , Trivalent,<br>PF |            | IM – Deltoid<br><input type="checkbox"/> L <input type="checkbox"/> R | Lot#:<br>Exp. Date:<br>VIS Date: |                 |