

Adult Workplace Flu Shot Consent Form

Personal Information

Full Name

Date of Birth

Phone Number

Email

Employer

Health Screening Questions

☐

I have had a severe reaction to a flu vaccine before

☐

I am allergic to eggs

☐

I have had Guillain-Barré Syndrome

☐

I am sick today (fever, illness, etc.)

Other Health Concerns

Consent

☐

I have read the information about the flu vaccine. I understand the benefits and risks and hereby consent to receive the influenza vaccination.

Signature

Date

