ATSU **Gutensohn Clinic**

800 W. Jefferson St., Kirksville, MO 63501
Kirksville Family Medicine (660) 626-2222 • Neurobehavioral Sciences (660) 626-2182
Osteopathic Manipulative Medicine (660) 626-2304 • Women's Health (660) 626-2211

FLU SHOT CONSENT FORM

Patient Information (Please Print)			
☐ ATSU Employee ☐ ATSU Spouse/Significant Other ☐ Gutensohn Clinic Patient	☐ KCOM Student ☐ KCOM Fellow ☐ Biomedical Sciences Student	☐ MOSDOH Student ☐ Truman Employee	
Last Name:	First Name:		MI:
DOB:	Gender: ☐ Male ☐ Female		
Street Address:			
City:	State:	Zip:	Phone:

SCREENING QUESTIONNAIRE

The following questions will help us determine which vaccines may be given today.		Yes	No	Don't Know
1	Are you sick today?	☐	☐	☐
2	Do you have allergies to medications, food, a vaccine component or latex?	☐	☐	☐
3.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems?	☐	☐	☐
5.	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?	☐	☐	☐
6.	During the past year, have you received a transfusion of blood or blood products, including antibodies?	☐	☐	☐
7.	Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
8.	Do you have a neurological disorder such as seizures or other disorders that affect the brain or have a neurological disorder that resulted from a vaccine?	☐	☐	☐
9.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐

I have read or have had explained to me the information on the vaccine information statement. I have had the chance to ask questions that were answered to my satisfaction. I have answered the screening questionnaire for injectable influenza vaccination truthfully and to the best of my ability. I believe I understand the benefits and risks of the influenza vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request

Patient Signature _____ Date _____

CLINIC USE ONLY

Form Reviewed By:	Lot # & Expiration Date:
Date Vaccinated:	Deltoid: ☐ Left ☐ Right
Signature:	Title: ☐ LPN ☐ RN