INFLUENZA VACCINE CONSENT FORM
PAT WALKER HEALTH CENTER

I have received the Influenza Vaccine Information Statement (VIS) dated 8/07/2015 and have had an opportunity to ask questions. I understand the benefits and risks of the influenza vaccination as described. I request that the vaccine be given to me or to the person named below for whom I am authorized to sign. *I have been advised to remain in the injection area for 15 minutes for post-injection observation. If I leave before this time I understand that I am leaving against medical advice.*

Name (please print) **Date of Birth** **Age**

Address **City**

Medication or vaccine reactions **Signature of person to receive vaccine (or parent or guardian)**

Date	Lot#	EXP	Dose	Site	Signature of person administering vaccine
	79PE5	6/15/2017	0.5 ml IM		