

**COMPLETE ONLY IF YOU HAVE MEDICARE B**

**CONSENT 2009-10  
SEASONAL INFLUENZA VACCINATION**

**PLEASE PRINT**

Last Name	First	Middle	Date of Birth
Telephone			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address	City	State	Zip

**Medicare B#** \_\_\_\_\_

***Please answer the following questions:***

1. Have you ever had a serious allergic reaction to eggs or a previous dose of influenza vaccine?  Yes  No
2. Are you sick right now with a fever or other symptoms?  Yes  No

I have read or had explained to me the information on the Influenza Vaccine Information Statement (08/11/09). I have had a chance to ask questions and these were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine and ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request.

**X** \_\_\_\_\_  
*Signature of person to receive vaccine or person authorized to make the request* *Date*

The 2009-10 influenza vaccine contains the following strains: A/Brisbane/59/2007, A/Uruguay/716/2007 and B/Brisbane/60/2008.

**(STAFF USE ONLY)**      \$20 Payment:       Submitted to Medicare

Manufacturer & Lot #: GSK AFLLA255BB      Expires: May 2010      Dosage: 0.5 mL

IM Deltoid Site Given:       Left       Right

Administered by \_\_\_\_\_ Date \_\_\_\_\_