KSB HOSPITAL
KATHERINE SHAW BETHEA HOSPITAL

Affix Patient Label Here

2024 SEASONAL INFLUENZA VACCINE CONSENT

NAME: _____

Date Of Birth: _____ **Physician:** _____

Address: _____

Phone: _____ **Email** _____

*Are you allergic to eggs? YES☐ NO☐

*Have you ever had a serious allergic reaction to the influenza vaccine or any other vaccine? YES☐ NO☐

*Were you ever paralyzed by Guillain-Barre Syndrome? YES☐ NO☐

*Currently are you moderately or severely ill? (People with a mild illness can get the vaccine) YES☐ NO☐

*I have been given the 8/6/2021 Vaccine Information Sheet (VIS)? ***You will be given this form at the Drive Thru Clinic.* YES☐ NO☐

X_____ DATE: _____
Signature of person to receive vaccine or person authorized to make the request, parent or guardian.

For KSB Staff Use Only:

Vaccine Name:_____

Vaccine Manufacturer: _____Vaccine Lot #_____Exp. Date:_____

Site of Injection: **Right** **Left** *Deltoid* Date Vaccine Administered: _____

Signature/Title of Vaccine Administrator_____