SVT Health&Wellness
A branch of Seldovia Village Tribe
Partnering in the Journey!

Consent for Influenza Vaccination

Patient Name: _____ Date of Birth: ____/____/_____

Address:_____City, State, Zip: _____

☐ Medicare ☐ Medicaid ☐ Uninsured ☐ Other Insurance _____ ☐ IHS

- I have received the Vaccine Information Statement (VIS) and have had a chance to ask questions and those questions were answered to my satisfaction. I believe I understand the benefits and risks of this vaccine and request the vaccine(s) be given to me, or to the above-named patient for whom I am authorized to make this request.
- I have been instructed that as a result of this vaccination I/patient may experience some side effects such as, but not limited to, the following:
  - Slight discomfort and/or bruising at the injection site
  - Muscle aches
  - Soreness of the arm
  - Joint aches and/or Weakness
  - Redness of the arm
  - Rash and/or Itching
  - Blushing and/or Tingling
  - Slight fever and/or Chills

Please answer the following questions:

1. Is the person to be vaccinated sick today?	❒ Yes	❒ No
2. Does the person to be vaccinated have an allergy to a component of the vaccine?	❒ Yes	❒ No
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	❒ Yes	❒ No
4. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	❒ Yes	❒ No

- I was given a copy of VIS Form and have read it.
- I request and authorize SVTHW to inform my Primary Care Provider that I have been given this vaccination.
- My Primary Care Provider is:_____ at _____.
  Physician Name Office Name

Immunization Administered by: SVT Health & Wellness, 880 E End Rd, Homer, AK 99603.

_____ _____
Patient/Parent/Guardian Signature Date

_____
If signed by Parent/Guardian, PRINT NAME