



1200000

PLACE LABEL HERE.  
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

**FLU VACCINE WAIVER FORM**

To be completed by the patient or legal representative:

- Are you allergic to eggs? ..... YES NO
- Are you allergic to thimerosal (contact lens solution)? ..... YES NO
- Are you allergic to chicken or chicken feathers? ..... YES NO
- Are you allergic to latex? ..... YES NO
- Have you ever had a severe allergic reaction? ..... YES NO
- Have you received another type of vaccine in the last 14 days? ..... YES NO
- Have you ever had a flu shot before?..... YES NO

I have had an opportunity to ask questions which were answered to my satisfaction.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship if other than the patient: \_\_\_\_\_

**TO BE COMPLETED BY CLINIC STAFF**

Charting in electronic medical record:

- Two patient identifiers
- Vaccine administration
- Patient understanding flowsheet

Education:

- Flu vaccine education handout given and reviewed with patient / family

Barriers to learning:  none  physical  emotional  cultural  educational  language

other \_\_\_\_\_

Barriers addressed by:  N/A \_\_\_\_\_

Response to learning:  demonstrates understanding  needs reinforcement/repetition  
 needs complete review  unable to complete teaching

Plan if unable to complete teaching: \_\_\_\_\_

Comments: \_\_\_\_\_

Signature: \_\_\_\_\_ RN LPN

**SEND COMPLETED FORM TO HIS**