DR. GARY BIRDSALL
MEDICAL CLINIC, LLC

102 W 112th Street, Cut Off, LA 70345

NAME: _____ DOS: _____

DOB: _____

You should not receive the Influenza vaccine if any of the following apply:

1) You have ever had a serious allergic reaction to eggs, formaldehyde, gelatin, or to a previous dose of the influenza vaccine.
2) You have a history of Guillain-Barre Syndrome (GBS).
3) You are ill (Unless approved by the provider).

Speak to your provider if you are pregnant. Influenza vaccine is indicated and recommended if your due date falls during the flu season (November to March).

Possible reaction: Mild: Soreness at the site of shot, fever, and body aches

Severe: Acute allergic reaction, high fever, confusion, difficulty breathing, hives, and rapid heartbeat would occur within a few minutes of shot.

Guillain-Barre Syndrome: progressive muscle weakness and paralysis may occur a week after the vaccine. This occurs in 1-2 cases per million persons vaccinated.

Questions You Must Answer:	**Circle Your Response**:
1) Are you ill today?	Yes / No
2) Are you allergic to eggs or egg products?	Yes / No
3) Have you ever had a severe reaction to flu vaccine?	Yes / No
4) Have you had Guillain-Barre Syndrome?	Yes / No
5) Are you allergic to gelatin or thimerosal?	Yes / No
6) Have you had a severe reaction to formaldehyde?	Yes / No

Consent:

I consent to take the Influenza vaccine. I have been provided with written and verbal information regarding both influenza and the influenza vaccine. The information provided has answered my questions/concerns regarding the vaccine.

_____ _____

Witness Patient

Site: _____

Lot:_____Exp:_____ Date: _____