

**SENIORS AND PEOPLE WITH DISABILITIES SERVICES  
STATE-OPERATED COMMUNITY PROGRAM**

**INFLUENZA IMMUNIZATION INFORMED CONSENT**

I hereby give the facility permission to administer an influenza vaccination annually, in the fall (October 1<sup>st</sup> through March 15<sup>th</sup>). To the best of my knowledge, I have not had an anaphylactic reaction to eggs. I have been instructed that as a result as a result of this vaccination, I may experience some side effects such as:

- Slight discomfort;
- Soreness of the arm;
- Redness of the arm;
- Slight fever (occasionally; and
- Muscle aches (occasionally).

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature/Title of Witness

\_\_\_\_\_  
Date

**Refused**

Reason: \_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, the responsible party for \_\_\_\_\_  
(Name of Representative) (Name of  
\_\_\_\_\_, who is my \_\_\_\_\_, and a client  
Client) Relationship  
of this facility, hereby give my permission for the facility to administer an influenza vaccination annually, in the fall (October 1<sup>st</sup> through March 15<sup>th</sup>). To the best of my knowledge, he/she has not had an anaphylactic reaction to eggs.

\_\_\_\_\_  
Signature of Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature/Title of Witness

\_\_\_\_\_  
Date

**Refused**

Reason: \_\_\_\_\_

PHYSICIAN'S SIGNATURE

DATE