Luna Beck, M.D.

Board Certified Internal Medicine

Influenza Vaccine Consent Form

Today's Date: _____

Last Name: _____ First Name: _____ Mi _____

Gender: _____ Age: _____ Date of Birth_____

Address:

_____ _____

City: _____ State: _____ Zip: _____

Questionnaire:

1. Have you ever received a flu shot before? _____
2. Do you have an allergy or have had a severe allergic reaction to eggs? _____
3. Have you ever had Guillain-Barre Syndrome?
(A viral illness resulting in neurological symptoms including paralysis) _____
4. Are you since or do you have a fever today?
(If yes, you should not receive vaccine) _____
5. Have you ever received a pneumonia shot before? _____
6. Are you or could be pregnant? _____

Patient Signature _____

Date Signed _____

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