

YUMA HOSPITAL & CLINICS

Influenza Vaccine Consent Form and Administration Record

2025-2026 Season

- ☐ VFC
☐ Employee
☐ Other

RECEIVED WITH CLINIC VISIT ☐

RECEIVED WITH HOSPITAL VISIT ☐

HIGH DOSE VACCINE GIVEN ☐ ≥ 65 years old ONLY ☐

Information about person to receive vaccine (Please Print)

Name: _____ Date of Birth _____
Last First MI

Address: _____ Sex: Male Female

City: _____ State: _____ Zip Code: _____

Phone #: _____ Doctor: _____

I have read or have been explained to me the Vaccine Information Statement about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. (parent or guardian)

X _____ Date: _____

Please circle your answer to the following questions:

- | | | |
|--|-----|----|
| 1. Have you received flu vaccine before? | Yes | No |
| 2. Did you have problems with previous flu shots? | Yes | No |
| 3. Are you ill today? | Yes | No |
| 4. Do you have allergies to eggs or to Thimerosal Mercury?
(a medication preservative)? (Please answer "NO" to an egg allergy if you CAN eat foods with egg in them.) | Yes | No |
| 5. Do you have a history of Guillian-Barre Syndrome (a paralysis problem)? | Yes | No |

- ☐ Medicare
☐ Medicaid
☐ Other Insurance

For Clinic Use Only

Clinic Site: AKRON CLINIC YUMA CLINIC YDH VIS Date: 01/31/2025

Date Vaccine Administered: _____ Dose Given: 0.25ml 0.5ml

☐ Fluzone PF HIGH DOSE 25-26 Sanofi Lot #UT8763FA Exp. 06/30/2026

☐ Fluzone PF Trivalent 24-25 Sanofi Lot #UT8826LA Exp. 06/30/2026

Site of IM injection: RDT or LDT or _____

Signature and title of vaccine administrator: _____

Nurse comments: _____



Yuma Clinic: 1000 West 8th Avenue - Yuma, CO 80759 970-848-5405
Akron Clinic: 82 Main Street - Akron, CO 80720 970-345-6336
Yuma Hospital: 1000 West 8th Avenue - Yuma, CO 80759 970-848-5405

Age Group	Dosage Schedule
9 years & older	0.5 ML: 1 dose
3-8 years	0.5 ML: 1 dose, If this is the child's first time receiving the vaccine, the child NEEDS a booster in 1 month.
6-35 months	0.25 ML: 1 dose If this is the child's first time receiving the vaccine, the child NEEDS a booster in 1 month

YUMA HOSPITAL & CLINICS

Consentimiento de Vacuna de Influenza y Registro de Administración Temporada 2025-2026

- ☐ VFC
☐ Employee
☐ Other

RECEIVED WITH CLINIC VISIT ☐

RECEIVED WITH HOSPITAL VISIT ☐

HIGH DOSE VACCINE GIVEN ☐ ≥ 65 years old ONLY ☐

Información de persona recibiendo vacuna (Por favor Imprima)

Nombre: _____ Fecha de Nac. _____
Apellido Nombre Inicial

Dirección: _____ Genero: Masculino Femenino

Ciudad: _____ Estado: _____ Código Postal: _____

Teléfono #: _____ Medico: _____

He leído o se me ha explicado la información sobre vacunación de la gripe y la vacuna contra la gripe. He tenido la oportunidad de hacer preguntas que fueron respondidas satisfactoriamente. Entiendo los beneficios y riesgos de la vacuna contra la influenza y pido que me la administren a mí o a la persona nombrada anteriormente por quien estoy autorizado a hacer esta solicitud. (padre o tutor)

X _____ Fecha: _____

Por favor responda las siguientes preguntas:

- | | | |
|---|-------|---|
| 1. Ha recibido la vacuna de influenza antes? | Si No | ☐ Medicare
☐ Medicaid
☐ Otro Seguro Med. |
| 2. Tuvo complicaciones con vacunas previas de influenza? | Si No | |
| 3. Esta enfermo hoy? | Si No | |
| 4. Tiene alergia al huevo o al Timerosal Mercurio? | Si No | |
| (un conservativo de medicamentos)? (Por favor responda "NO" a alguna alergia al huevo al SI poder comer alimentos conteniendo huevo.) | | |
| 5. Tiene historial de Síndrome Guillian-Barre (un problema de parálisis)? | Si No | |

Solo Para el Uso de Clínica

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