

Fort Bayard Medical Center
INFLUENZA IMMUNIZATION INFORMED CONSENT

I hereby give Fort Bayard Medical Center permission to administer an **influenza vaccination** annually, in the fall. I have been instructed that as a result of this vaccination. I may experience some side effects such as:

- Slight discomfort
- Soreness of the arm
- Slight fever (occasionally)
- Muscle aches (occasionally)

____/____/____
Date

Signature—Resident

____/____/____
Date

Signature—Responsible Party
(If applicable)

____/____/____
Date

Signature--Witness

Recommended per Dr.'s Order

____/____/____
Date

Resident's Name: _____ Admission No: _____