



# Marathon Health™

Date of Birth: \_\_\_\_\_

If “Yes” to any of the below, consult a provider before receiving a vaccine:

- |   |           |
|---|-----------|
| 1. Is the person to be vaccinated sick today?   | Yes or No |
| 2. Does the person to be vaccinated have an allergy to a component of the vaccine (including eggs)? | Yes or No |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?    | Yes or No |
| 4. Has the person to be vaccinated ever had Guillain-Barre Syndrome?                                | Yes or No |

**If person to be vaccinated is 8 years old or younger and receiving the influenza vaccine for the first time, a booster vaccine should be administered in 4 weeks. Please schedule the booster before leaving your appointment today.**

By signing below, I hereby certify that:

- My answers to the above questionnaire are true and complete to the best of my knowledge.
- I have had an opportunity to ask Marathon health center staff questions about the risks and benefits of the inactivated influenza vaccine, and my questions have been answered to my satisfaction.
- I have read or had explained to me the CDC's "Inactivated Influenza Vaccine Information Statement".

**I understand the risks and benefits of the inactivated influenza vaccine I have chosen to receive, and hereby give consent to Marathon Health and its staff to administer the inactivated influenza vaccine to me.** I agree to wait in the health center for 15 minutes after receiving the vaccine in order to allow health center staff to monitor for any delayed vaccine reaction.

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Signature of Patient	Date
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If the person receiving the vaccine is under a legal guardianship, the legal guardian must sign below to confirm his or her consent to the administration of vaccine to the patient.

Signature of Legal Guardian	Date
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**Marathon Health Ambassadors:** Use the area below to document the proper procedure for charting and dispensing.

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Dispensed from inventory: ☐

*If unable to chart/dispense at time of administration, capture below information and update systems accordingly when available:*

Site of injection: R / L deltoid      Signature of administrator:      Date: