West Caldwell Health Council
Flu/Fit Consent

Patient Name (Last, First): _____ **DOB:** _____
Medicare #: _____ **Medicaid #:** _____
Other Insurance: _____

	YES	NO
1. Do you have a serious allergy to eggs?		
2. Do you have a fever with a temperature above 100° F?		
3. Have you ever had a serious reaction to a previous dose of flu vaccine?		
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
5. Are you between the ages of 50-75? If yes, please answer next question		Stop here
6. When was your last colon cancer screening? Colonoscopy _____ Fit-Kit _____ Never Unknown ***If colonoscopy > 10 years ago or Stool Card >1 year ago, you are eligible for a Fit/FOBT test today**		

I give consent to West Caldwell Health Council to administer the vaccine(s) listed below. Information regarding the vaccines, benefits, and risks have been reviewed with me and I have had all my questions answered to my satisfaction. If I am between the ages of 50 and 75 and being offered a FIT/FOBT kit for colorectal cancer screening today, it has been explained to me.

Signature of Patient / Guardian: _____ Date: _____

Office Use Only:

Fit/FOBT Eligible: □Yes □No • Fit/FOBT Test given? □Yes □No • Order Entered: _____
Most recent screening date in flow sheet: □Yes □No □ Records requested (if result not in chart)

Stock (circle one): State / Private • Allergies: _____
Vaccine: _____ Dose: _____
Manufacturer: _____ Lot #: _____ Exp. Date: _____
Injection Site / Route: R or L _____

Patient waited in office x15 minutes: Yes No

Administered By: _____ Date / Time: _____

Initials of Reviewer: VIS Sheet(s) Present: _____

EMR: _____ **NCIR:** _____