

## 2017-2018 QUADRIVALENT INACTIVATED INFLUENZA VACCINE CONSENT

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ Sex: Male /Female

**Please read and check your answer to the following questions:**

- Y  N Have you had a fever of 101° F. or higher in past 48 hours?
- Y  N Have you ever had an allergic reaction to a previous influenza vaccination?
- Y  N Do you have a severe allergy to eggs?
- Y  N Have you ever had Guillan Barré Syndrome (a severe paralytic illness)?
- Y  N Do you have an illness or take medication causing immunodeficiency?
- Y  N Are you allergic to any medications? (please list): \_\_\_\_\_
- Y  N Are you currently taking medicines on a regular basis? (please list): \_\_\_\_\_
- Y  N I would like to receive the INFLUENZA vaccination from the Campus Health Center.
- Y  N I have read the Vaccine Information Statement (VIS) dated 08/07/2015 provided me about INFLUENZA vaccine and the benefits and risks associated with receiving INFLUENZA vaccination.

I certify that I have read this form, that I fully understand the authorizations, acknowledgements, consents and waivers given above, that I was given ample opportunity to ask questions and that any questions have been answered satisfactorily. The signature below indicates my request and consent for the INFLUENZA vaccination.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

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### Office Use Only

**Vaccine:** Fluzone

**Manufacturer:** Sanofi

**Lot #:** UI826AB

**Expires:** 06/30/2018

**Dosage:** 0.5 cc IM

**Site:** R or L Deltoid

**Administered by:** \_\_\_\_\_

**Date:** \_\_\_\_\_