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*

Office Use Only

Vaccine: Fluzone **Manufacturer:** Sanofi **Lot #:** UI852AB **Expires:** 06/30/2018

Dosage: 0.5 cc IM **Site:** R or L Deltoid **Administered by:** _____

Date:_____