



Student Health Services

2019-20 Influenza Vaccination Screening and Consent Form

NAME: Last _____ First _____ MI: _____ AGE: _____

Date of Birth: _____ Are you: Staff Faculty Sodexo Student PAWS ID#: _____

You will be receiving Fluzone® Quadrivalent Vaccine (Sanofi Pasteur). This vaccine contains 4 KILLED flu vaccine strains. It does NOT contain the preservative, thimerosal. The vaccine is given by injection into the deltoid muscle of the upper arm. You should not receive this vaccine if you have had a severe allergic reaction (e.g., anaphylaxis) to any flu vaccine component, including eggs, or egg products, or to a previous flu vaccination. Fainting has been associated with the administration of injectable vaccines and has resulted in serious injuries. We, therefore, recommend that you sit for 15 minutes before leaving the room. Annual vaccination is needed because immunity declines during the year after vaccination, and because influenza virus strains change from year to year.

Please answer the following questions:

1. Are you sick today?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Have you ever had a severe allergic reaction to egg protein?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Have you ever had a severe allergic reaction to any flu vaccine component?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Have you ever had a severe allergic reaction to influenza vaccine in the past?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Have you ever had Guillain-Barré Syndrome (a severe paralytic illness called GBS) within 6 weeks after receiving a previous influenza vaccination?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Do you have a bleeding disorder such as hemophilia or are you on anticoagulant (blood thinner) therapy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Do you have court-appointed legal guardian? If so, has your legal guardian signed this consent?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Are you 18 years of age or older? If not, has your parent/legal guardian signed this consent?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Read, Sign and Date:

I have read or had explained to me the information on the Influenza Vaccine Information Statement (VIS) dated 8/7/15. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine and ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request (*parent/legal guardian*). I understand that I should wait 15 min after vaccination before leaving the area.

Signature of person receiving vaccine (or parent/legal guardian, if applicable)

Date

STAFF USE ONLY

Fluzone® Quadrivalent 2019-20 Influenza Virus Vaccine – Sanofi Pasteur, 0.5 mL Lot#: _____ Expires: 6/30/20

Site Given: IM Deltoid – Left IM Deltoid – Right

Form Reviewed and Vaccine Administered by _____ Date _____