

## Inactivated Influenza Vaccine Consent & Administration (≥ 18 years of age)

Name (Print) \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone No. \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ Employee ID # (as applicable) \_\_\_\_\_

Insurance plan/payor (if known) \_\_\_\_\_

**Complete the following if you are an employee's dependent authorized to receive care in the Premise Health facility.**

Dependent Relationship to employee/subscriber:  Spouse  Child  Other \_\_\_\_\_

The influenza vaccine is prepared using a combination of strains of both the influenza A and influenza B viruses based upon the recommendations of the Centers for Disease Control and Prevention (CDC) and the Advisory Council on Immunization Practices (ACIP). This vaccine is prepared using an inactivated/killed form of the flu virus and it is therefore impossible for the vaccine to cause the flu. Possible side effects of the vaccine are included on the Vaccine Information Statement.

**Please answer the following questions:**

- |  |                              |                             |                              |
|--|------------------------------|-----------------------------|------------------------------|
| Have you ever received the influenza vaccine?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                              |
| Are you now, or could you possibly be, pregnant?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Are you allergic to any medications, thimerosal, eggs or egg products?                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                              |
| Have you ever had an allergic reaction to the flu vaccine or other vaccine?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                              |
| Are you currently sick or have a fever?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                              |
| Have you ever had Guillain-Barré Syndrome or other neurological (nervous system) disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                              |

I have read the provided influenza Vaccine Information Statement, and have had any questions answered to my satisfaction. I believe that I understand the benefits and risks of the influenza vaccine and request that the vaccine be administered to me. I acknowledge that no guarantees or assurances have been made to me concerning the results of administration of the vaccine. I release \_\_\_\_\_, and Premise Health and its employees from any liability for any adverse reaction to the vaccine.

I acknowledge that I have been given the opportunity to receive the Premise Health Notice of Privacy Practices ("Notice") regarding uses and disclosures of information regarding me and my health ("Health Information"), and a copy of this Notice can be provided to me.

Recipient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**NOTE: If you have never received a flu vaccine, it is recommended that you wait in the clinic/administration area for 15 minutes after receiving the injection. If this is your first flu vaccine, and you choose not to wait, please initial on the following line.**

	<b>Initials</b>													
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Brand Name</td> <td>Afluria</td> </tr> <tr> <td>Manufacturer</td> <td>Seqirus</td> </tr> <tr> <td>Lot Number</td> <td>P100247210</td> </tr> <tr> <td>Expiration Date</td> <td>06/30/2021</td> </tr> </table>	Brand Name	Afluria	Manufacturer	Seqirus	Lot Number	P100247210	Expiration Date	06/30/2021	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Dose</td> <td></td> </tr> <tr> <td rowspan="2">Injection Site</td> <td style="text-align: center;">Deltoid</td> </tr> <tr> <td> <input type="checkbox"/> Right    <input type="checkbox"/> Left                 </td> </tr> </table>	Dose		Injection Site	Deltoid	<input type="checkbox"/> Right <input type="checkbox"/> Left
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	<input type="checkbox"/> Right <input type="checkbox"/> Left													

VIS, dated \_\_\_\_\_, provided and vaccine administered on \_\_\_\_/\_\_\_\_/\_\_\_\_, at \_\_\_\_:\_\_\_\_ a.m. / p.m. by:

\_\_\_\_\_  
Staff Member Printed Name

\_\_\_\_\_  
Staff Member Signature