



**Occupational Health**

SEASONAL INFLUENZA VACCINATION CONSENT FORM

**2020/2021**

***\*\*COMPLETE ALL INFORMATION REQUESTED ON THIS FORM\*\****

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| **Name (PLEASE PRINT):** |  |  **DOB:** |  |

***If you have had recent chemotherapy, radiation therapy, or steroids (except inhaled), these conditions may decrease the effectiveness of the vaccine. However, influenza vaccination is still encouraged.***

***Influenza vaccination is recommended for any woman who will be breastfeeding during the influenza season, or will be pregnant during the influenza season. Vaccination can occur in any trimester.***

**YES NO**

**[ ]  [ ]** 1. I have reviewed the CDC flu vaccine information statement and had my questions answered.

**[ ]** **[ ]** 2. Are you allergic to eggs or egg products?

**[ ]** **[ ]** 3. Are you allergic to thimerosal (a preservative) other than contact lens sensitivity?

[ ]  [ ]  4. Have you ever had Guillain-Barre Syndrome within 6 weeks of taking a flu shot?

[ ]  [ ]  5. Have you ever had an anaphylactic reaction to the influenza vaccine?

[ ]  [ ]  6. Are you allergic to latex?

[ ]  [ ]  7. Did you receive a flu shot last year?

***YES*, I consent to have the influenza vaccine given to me.**

I have been given and have read or have had explained to me, the information in the Vaccine Information Statement(s) for the Influenza Vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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|  |  |  | **\*\*\*Office Use Only\*\*\*** |  |
| **FLU VAX** | **Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Lot # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Exp. Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Site:** | **Left deltoid** | **Right deltoid** | **Intra-nasal** | **Dose: 0.5 ml /Other \_\_** | **Temperature:\_(optional)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RN/LPN/MA/RT** | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
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