STUDENT
HEALTH CLINIC

INFLUENZA (FLU) VACCINE CONSENT FORM
2022-2023 SEASON

Name: _____ ID#: _____
(Bear ID or SSN)

Address: _____
Street City State Zip Code

Please **circle** one:

Student Staff Faculty

Please check if **TRUE (✓):**

_____1. I have an allergy to eggs. I have had a dangerous reaction after eating or handling eggs.

_____2. I have had a serious reaction to an influenza vaccination (flu shot) in the past.

_____3. I have been paralyzed with Guillain-Barre' syndrome.

_____4. I am ill with more than a minor cold and have a fever at this time.

_____5. I have had a reaction to components in the flu vaccine in the past.

If you have any questions, please ask now or check with a physician before receiving the vaccine. If you have any significant reactions, SEE YOUR PHYSICIAN IMMEDIATELY.

INFLUENZA CONSENT STATEMENT

I have read the Centers for Disease Control vaccine information statement: *"Influenza Vaccine Inactivated: What you need to know"*, dated 08/06/2021. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and ask that the vaccine be administered to me."

Signed: _____ Date: _____

THIS SECTION TO BE COMPLETED BY NURSING PERSONNEL

Date: _____

Administered Influenza Vaccine 0.5 ml IM:

- ❑ Right Deltoid
- ❑ Left Deltoid

FLUCELVAX, Quadrivalent

- ❑ Lot Number **AS3402B,** Expiration date 05/31/2023
- ❑ Lot Number **AS3612B,** Expiration date 05/31/2023
- ❑
- ❑

Patient instructed to notify physician immediately for any significant reaction. ❑ Yes ❑ No

Patient given:

- ❑ Acetaminophen 325 mg, 2 tablets
- ❑ Ibuprofen 200 mg, 2 tablets
- ❑ Declined pain reliever

Signature of Vaccine Administrator: _____