

Influenza Vaccine Consent Form

Section 1: Information for Individuals receiving the 2011-12 Influenza Vaccine (please print)

NAME (Last)	(First)	(M.I.)	DATE OF BIRTH month _____ day _____ year _____
ADDRESS			Cell phone no. _____
CITY	STATE	ZIP	

Section 2: Vaccine Eligibility

A. Please mark YES or NO for each question.	YES	NO
1. Do you have a serious allergy to eggs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Do you have an allergy to Thimerosal?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Do you have any other serious life-threatening allergies? Please list: _____	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a serious reaction to a previous dose of flu vaccine?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) after receiving a vaccine?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

B. Please mark Yes or NO for each question as applicable.	YES	NO
1. Have you been vaccinated with any vaccine within the past 30 days? Vaccine: _____ Date given: month _____ day _____ year _____	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Do you have any of the following: asthma, diabetes (or other metabolic disease), disease of the lungs, heart, kidneys, liver, nerves, blood? Please list:	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Do you have a weakened immune system (for example cancer, or medications such as steroids or those used to treat cancer, or An immune deficiency)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Women only: Are you pregnant?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Section 3: Consent

CONSENT FOR VACCINATION:

I have read or had explained to me the Influenza Vaccine Information Statement for the 2011-12 influenza vaccine. I understand the risks and benefits of this vaccine.

I GIVE CONSENT to have the St. Norbert College Health and Wellness Services medical staff to vaccinate me with the 2011-12 influenza vaccine.

Signature _____ Date: month _____ day _____ year _____

Section 4: Permission to Release Information

I consent to have this immunization logged in the Wisconsin Immunization Registry (WIR) and understand that I can access that record at any time. YES NO This is a HIPAA compliant site and complies with all the regulatory standards for protected health information.

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dosage	Vaccine Manufacturer	Lot Number Circle Correct Lot #	Name and Title of Vaccine Administrator
2011-12 Influenza	/ /	<input type="checkbox"/> IM	5ml	Sanofi Pasteur Inc.	UH455AD UH462AB UH462AC	Registered Nurse
2011-12 Influenza	/ /	<input type="checkbox"/> IM				