



INFLUENZA VACCINATION CONSENT FORM 2018

Please Print Your Name Below:

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Last Name	First Name	Middle Initial	Fermilab ID
			Yes No
Are you 18 years old or older?			___ ___
Have you ever had an allergic reaction to a previous influenza vaccination?			___ ___
Do you have an allergy to eggs, latex, thimerosal, neomycin, or polymyxin?			___ ___
Have you ever been diagnosed with Gullain-Barre Syndrome?			___ ___
Do you have a fever, illness, or active infection?			___ ___
Do you have an active neurological disorder?			___ ___
Do you have a known or suspected pregnancy, or are you nursing?			___ ___

(Written consent from your prenatal MD is required to have the vaccine if you are pregnant, from pediatrician if you are nursing.)

I have read or have had explained to me the influenza vaccine information statement (2018 – 2019). I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me.

_____ Date _____

Signature

Date vaccinated: _____ VIS Offered: ___Yes

Manufacture: Seqirus Flucelvax Quadrivalent Lot Number: 252667 Exp. Date: 06/30/2019

Site of Injection: Deltoid ___Right ___Left

Signature of medical provider: _____