The
Work Place

Occupational Health Department of
Saint Francis Hospital and Health Centers
845-431-8740

INFORMED CONSENT FOR RECEIPT OF INFLUENZA VACCINE

COMPANY NAME: ______________________________

PLEASE PRINT CLEARLY

Last Name:________________________ First Name:________________ Middle Initial:_____

Street: _________________________City:____________________ State: ______ Zip ________

Phone #: (_____)________________Date of Birth:______________

❑ I did ❑ did not … receive the flu vaccine last year.
❑ I do ❑ do not … currently have a fever or the symptoms of an acute infection.
❑ I am ❑ am not … pregnant. ❑ N/A ***(If pregnant, a doctor's note is required for vaccination)***.
❑ I am * ❑ am not … taking **coumadin or other similar blood thinners or theophylline**.
❑ I am * ❑ am not … allergic to **epinephrine (adrenaline)**. *(Used to treat allergic reactions)*
❑ I am * ❑ am not … allergic or sensitive to **gentamicin or thimerosol merthiolate**.
❑ I am * ❑ am not … allergic or sensitive to **chicken eggs or chicken egg products.**
❑ I am * ❑ am not … currently ill with an active neurological disease.
❑ I do * ❑ do not … have a history of Guillain-Barre Syndrome (GBS).
❑ I have * ❑ have not … ever been advised by physician not to receive the influenza vaccine.
* If yes, do not immunize

I have read the CDC Vaccine Information Statement or had explained to me the attached information about influenza disease, vaccine, and special precautions. I have had an opportunity to ask questions about influenza disease, and the respective vaccines which were answered to my satisfaction and I certify that I am 18 years of age or older. I understand the benefits and risks of the influenza vaccine and I request, and give my consent that the influenza vaccine be given to me or to the person named above of whom I am the parent, guardian, or authorized person.

Recipient's Signature: ______________________________ Date:____________________

OFFICE USE ONLY

Date: ________________________

Nurse who administered: _____________________

❑ Doctor's note attached *(only if ill or pregnant)*

Manufacturer: _______________________

Influenza Vaccine Lot #: _______________

Exp. Date ___________________________

Site of Injection: ❑ left arm ❑ right arm

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