**Saint Mary’s College**

**Health and Counseling Center**

**Influenza Virus Vaccine Consent Form and Administration Record**

**Fluzone 2016/2017 Formula**

**Strains: A/California/07/2009 (H1N1), A/Hong Kong 4801/2014 X-263B (H3H2)**

**B/Phuket/30732013 (B Yamagata lineage) and B/Brisbane/60/2008 (B Victoria lineage).**

\_\_\_Student \_\_\_Employee

***INFORMATION ABOUT THE PERSON TO RECEIVE VACCINE*** (**PLEASE PRINT CLEARLY**)

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: F \_\_\_ M \_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_**

**Last First M.I.**

**Phone (Cell or Campus): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Year of Graduation**: **\_\_\_\_\_\_**

**Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_**

**NO YES**

**1. Have you been vaccinated for the flu before? \_\_\_\_\_ \_\_\_\_\_**

**2. Did you have any problem with previous flu shots? \_\_\_\_\_ \_\_\_\_\_**

**3. Are you currently ill or feverish? \_\_\_\_\_ \_\_\_\_\_**

**4. Do you have an allergy to chicken eggs, chicken,**

**chicken feathers or chicken dander? \_\_\_\_\_ \_\_\_\_\_**

**5. Do you have a history of Guillian-Barre Syndrome? \_\_\_\_\_ \_\_\_\_\_**

**6. Do you have any known medication allergies? \_\_\_\_\_ \_\_\_\_\_**

**7. Do you have any known bleeding disorder, hemophilia,**

**thrombocytopenia, or on anticoagulant therapy? \_\_\_\_\_ \_\_\_\_\_**

**I have read or have had explained to me in the Vaccine Information Statement about influenza and the influenza vaccine. 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**

**given to me.**

**X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of person to receive vaccine**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_For Clinic/Office Use Only\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinic: Saint Mary’s College Health and Counseling Center**

**Vaccine Manufacturer and Lot Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dose: 0.5cc Site of Injection: Rt. Deltoid: \_\_\_\_\_\_\_ Lt. Deltoid: \_\_\_\_\_\_ or \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature and Title of Vaccine Administrator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**