Stormont-Vail HealthCare

2011-2012 SEASONAL INFLUENZA CONSENT/DECLINATION FORM

LAST NAME FIRST NAME MI	VOLUNTEER EMPLOYEE ID #	TODAY'S DATE	
VOLUNTEER POSITION/TITLE	VOLUNTEER SRV **DEPARTMENT**	BIRTH DATE	AGE
PRIMARY CARE PHYSCIAN ***Only If you are a Cotton O'Neil patient.)***			

I understand influenza is a contagious viral infection of the respiratory tract that is easily spread from person to person via respiratory droplets when an infected person coughs or sneezes, or when someone touches a surface contaminated with the virus. I also understand the influenza immunization is the most effective way to prevent the spread of infection and its complications to and from patients, coworkers, family members, and other close contacts. The vaccine also helps reduce influenza-like illness and absenteeism from work. The influenza vaccine also has the potential to prevent persons at highest risk of complications from developing severe influenza-related illness and death. I have reviewed and read the Vaccine Information Statement (dated 07/26/11) posted on SVNet. I understand the benefits and risks of the influenza vaccination as described. I have had an opportunity to ask and receive answers to questions asked. I understand that the information I write must be easy to read. Finally, the information I have furnished on this form and to the Employee Health Nurse/Vaccine Administrator is true and correct.

☐ I **decline** participation in the Stormont-Vail Influenza Vaccine Program due to receiving the 2011-2012 seasonal vaccine elsewhere. . *(Documentation must be attached to this form.)*

☐ I **consent** to the influenza vaccine. *(Please answer each question below.)*

REQUESTED: ANSWER EACH QUESTION

1. Have you ever had the influenza vaccine? Yes No
2. Have you had a severe reaction after a previous dose of influenza vaccine? Yes No N/A
3. Have you ever had a severe allergy to any vaccine component? Yes No N/A
4. Have you experienced hives after eating eggs or egg products? Yes No N/A
5. After eating eggs or egg products, have you experienced hypotension, wheezing, nausea/vomiting, or required an epinephrine shot or emergency medical attention? Yes No
6. Do you currently have a moderate or severe illness with a fever (100 F or higher)? Yes No
7. Do you have a history of Guillain-Barré Syndrome? Yes No

A "YES" response to the above will require review by the vaccine administrator prior to vaccination.

After review the vaccine administrator may determine that it is not safe for you to receive the vaccine and require you to consult your Primary Care Physician to have the Medical Contraindication Declination Form completed. This form must be returned to the Employee Relations department no later than **October 28, 2011**.

______________________________ **Signature OR Parental Signature if under age 18 years**

______________ **Date**

VACCINE ADMINISTRATION SECTION

Manufacture: Afluria® CSL Biotherapies **Lot Number**: ☐ N55406 ☐ N56506A **Expiration Date:** ☐ 06/09/12 ☐ 06/27/12

Injection site: ☐ **R deltoid** ☐ **L deltoid**

Administered by ______________________________ *Signature and Credentials* **Date/Time** ______________________