Stormont Vail Health
2019-2020 Seasonal INFLUENZA
Vaccination CONSENT form

PLEASE PRINT. COMPLETE EACH FIELD & ANSWER ALL QUESTIONS.

LAST NAME	FIRST NAME	MI	EMPLOYEE ID #	TODAY'S DATE
POSITION/TITLE	DEPARTMENT		BIRTH DATE	AGE
Name of Your Primary Care Provider (physician/PA/APRN)				

Please answer each question below. Your answers determine what vaccine type is best and safest for you to receive.

VACCINE QUESTIONNAIRE:

1. Have you ever had the influenza vaccine? Yes No
2. In the last 24 hours, have you had a moderate or severe illness with a fever (100° F or higher)? Yes No
3. Have you had a severe (life threatening) reaction after a previous dose of influenza vaccine? Yes No N/A
   If yes, describe. _____
4. Do you have a history of Guillain-Barre Syndrome related to receiving an Influenza vaccine? Yes No N/A

BY SIGNING BELOW I AGREE TO:

1. Follow the "Seasonal Influenza Program and Requirement for Health Care Workers" policy;
2. Report suspected or confirmed influenza-like symptoms per the "Reporting Requirements for Healthcare Workers with Infectious and/or Communicable Disease" policy prior to reporting to work; and,
3. Report a moderate or severe vaccination reaction in Stormont Vail's electronic reporting system (Verge) per the "Reporting Procedure for Employee Incidents and Safety Hazards" policy.

Lastly, my signature indicates I have reviewed and read the Vaccine Information Statement (dated 08/15/19) posted on SVnet. I understand the benefits and risks of the influenza vaccination as described. I consent to receiving the seasonal influenza vaccination and authorize this information to be released to my primary care provider noted above.

_____ _____

Signature **Date**

VACCINE ADMINISTRATION SECTION

Vaccine Sticker

FLULAVAL

(Circle correct lot/expiration or write information)

Lot # YH595 Exp. 06/12/2020

Lot # 3A929 Exp. 06/25/2020

Lot # _____ Exp. _____

FLUAD

(Circle correct lot/expiration or write information)

Lot # 260389 Exp. 05/31/2020

Lot # _____ Exp. _____

Injection Site

☐ Lt deltoid

☐ Rt deltoid

OTHER

☐ _____ *(vaccine type)*

Lot # _____ Exp. _____

Administered By: _____ **Date/Time**_____

(Signature with credentials)

Administrator's Printed Name: _____ Mary P. Jones, BSN, RN / Tanya Twombly, LPN