# Stormont Vail Health
## 2017-2018 SEASONAL INFLUENZA CONSENT FORM

**PLEASE PRINT CLEARLY, COMPLETE EACH FIELD & ANSWER EACH APPLICABLE QUESTION.**

| LAST NAME | FIRST NAME | MI | EMPLOYEE ID # | TODAY'S DATE |
|---|---|---|---|---|
| POSITION/TITLE | DEPARTMENT | | BIRTH DATE | AGE |
| Name of Employee's Primary Care Provider | | | | |

***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. | Do you currently have a moderate or severe illness with a fever (100 F or higher)? | Yes | No | |
| 3. | Have you had a severe reaction after a previous dose of influenza vaccine? | Yes | No | N/A |
| 4. | Have you ever had a severe allergy to any vaccine component? | Yes | No | N/A |
| 5. | After eating eggs or egg-containing food, do you experience hypotension, wheezing, nausea or vomiting, or required an epinephrine shot or emergency medical attention? | Yes | No | |
| 6. | Do you have a history of Guillain-Barre Syndrome related to receiving an Influenza vaccine? | Yes | No | |

### BY SIGNING BELOW I AGREE TO:

1. Follow the "Seasonal Influenza Program and Requirement for Health Care Worker" policy;
2. Report suspected or confirmed influenza-like symptoms per the "Reporting Requirements for Healthcare Workers with Infectious and/or Communicable Disease" policy; and,
3. Report a moderate or severe vaccination reaction in SVH's electronic reporting system 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 08/07/15) 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**

Injection site
- ☐ Lt deltoid
- ☐ Rt deltoid

**REGULAR (up to 64 yrs old)**
☐ Flulaval
Lot #_____ Exp. _____

**HIGH DOSE (65 yrs and older)**
☐ Fluad
Lot #_____ Exp. _____

**OTHER**
☐ Flublok
Lot #_____ Exp. _____

**Administered By**_____
(signature with credentials)

**Date/Time**_____