University Medical Center Employee Health Services
2015 – 2016 Influenza Vaccination Consent and Documentation

Please complete all information/data collection sections of this form.
Please Print Clearly.

Demographics:

Name: _____DOB:_____ LAST 4 SS# _____

Address: _____City/State: _____

Zip Code: _____ Phone Number: _____ ☐ Male ☐ Female

Job Information:

Department:_____ Job Title:_____

Please check the first category that applies:
☐1. UMC Employee (You receive a paycheck from ILH) ☐2. Contract Employee ☐3. Volunteer

Physicians: ☐4. LSU Staff/Fellow ☐5. LSU Resident ☐6. Tulane Staff/Fellow ☐7. Tulane Resident

☐ I have already received the 2015 - 2016 Influenza vaccine elsewhere.

Documentation is attached. Signature:_____

It is important that the following questions are answered accurately

Y or N

☐	☐	Have you ever had a severe (life threatening) allergic reaction to any component of the vaccine, including egg or egg protein or to a previous dose of any influenza vaccination?
☐	☐	Do you have a history of Guillain–Barre Syndrome (a severe paralytic illness, also called GBS) that has occurred within 6 weeks of receipt of a prior influenza vaccine?
☐	☐	Do you have fever of 101 or an active respiratory or other infection or illness right now?

If you answer yes to any of the above, please notify the immunization staff. If you have any questions or are not sure of any of your answers, please ask now or check with your physician.

Consent:

- I have read, or have had explained to me, information about influenza disease and the seasonal influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I agree to allow information about the influenza vaccination given to me to be released to other medical care providers to avoid the administration of unnecessary vaccinations and to determine immunization status.

Employee Signature: _____ Date:_____

For Office Use Only:

Manufacturer: _____ **Site**: ☐L Deltoid ☐R Deltoid
Lot#_____ Dose: 0.5ml IM
Exp. Date: _____ VIS Date of Publication**:** _____
Administered By: _____Print Name: _____
Date: _____ Time: _____ Comment: _____