Influenza Vaccination 2021-2022 Consent Form

Print Name: _____ DOB: _____ Sex: _____

Phone #:_____ Personal Email: _____

Do you have current UHC insurance through Lumen? ☐ Yes ☐ No

Are you a Lumen: ☐ Employee ☐ Spouse ☐ Dependent

Vaccine Information Statement (VIS) provided and consent for vaccination:

Please refer to the inactivated influenza vaccine VIS
Edition Date: 08/2020 @ cdc.gov/vaccines/hcp/vis/about/facts-vis.html

I have read the accompanying vaccine information statement. I have had an opportunity to ask questions and understand the benefits and risks of the vaccine and elect to be vaccinated. I understand that like all medical treatments, there is no guarantee that I will become immune or that I will not experience adverse effects of the vaccine. I acknowledge that:

- The 2021-2022 vaccine includes H1N1, H3N2, and two B strains.
- I cannot get influenza from the vaccine because the vaccine offered to me does not contain live virus.
- Any previous vaccination I received for influenza provides immunity for only a few months therefore annual vaccination is necessary for ongoing protection.
- The most common side effects are pain, redness, and swelling where the shot is given, muscle aches, tiredness, headache, or fever.
- If administered to immunocompromised persons, including those receiving immunosuppressive therapy, the expected immune response may not be obtained.
- I agree to remain in the facility where vaccine is given for at least 15 minutes after vaccination if it is my first time being vaccinated.

_____ _____/_____/_____
Patient Signature *Date*

Medical contraindication(s) (Check all that apply):

☐ Allergy to vaccine components

☐ History of Guillain–Barré syndrome within 6 weeks of previous influenza vaccination

☐ Current febrile illness (Temp > 101.5°F)

_____ _____/_____/_____
Medical Staff Signature *Date*

Vaccine Administration Record:

Type of vaccine administered: ☐ Sanofi-Fluad, Quadrivalent ☐ Sequiris-Fluad Quad–*High Dose ≥ 65 yrs*

Lot number: _____ **Expiration date**: ____/____/_____

Administration Details—Route: Intramuscular **Amount:** 0.5mL **Site:** ☐ Left ☐ Right ☐ Deltoid

Person administering vaccine: ☐ MA ☐ SN ☐ NP **Date:** ____/____/_____ **Time:**

_____ _____ AM

_____ PM