Influenza Vaccination 2024-2025 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: 08/2/2024 @ https://www.cdc.gov/vaccines/hcp/about-vis/

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 2024-2025 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

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