PROVIDENCE
COLLEGE

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INFLUENZA CONSENT FORM

Last Name	First Name	MI	Age	D/O/B	□ Male □ Female

Street Address (include Apt # if applicable)	City	State	Zip

Email Address:	Phone Number	Name of Physician:

SCREENING FOR FLU VACCINE ELIGIBILITY

1. Any serious allergy to eggs?	Yes	No
2. Ever had a serious reaction to previous dose of flu vaccine that required medical attention?	Yes	No
3. Ever had Guillain-Barre Syndrome (temporary severe muscle weakness) after receiving flu vaccine?	Yes	No
4. Any allergy to Thimerosol or Latex?	Yes	No

DO NOT WRITE BELOW THIS LINE UNTIL YOU APPEAR FOR YOUR SHOT

VACCINE ADMINISTRATION RECORD & WAIVER OF LIABILITY

I have read or have had explained to me the information provided about influenza and influenza vaccine. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to sign. I hereby release *Providence College* from any and all liability associated with the administration and potential side effects of the vaccine.

This record is evidence and/or documentation that you have received the flu vaccine, and it will be filed with *Providence College Health Services*. They will record what vaccine was given, when the vaccine was given, where the vaccine was given, the name of the company that made the vaccine, the vaccine's lot number, and the name and title of the person who gave the vaccine.

I certify that I have received and/or reviewed a Notice of Privacy Practice provided by *Providence College.*

CLIENT SIGNATURE: _____ **DATE:** _____

FOR ADMINISTRATIVE USE ONLY **VIS Date: 8 / 0 7 / 1 5**

Vaccine	Route	Manufacturer	Lot No.	
Influenza	*RA* *LA*			**Signature of Vaccine Administrator**_____ **Date vaccination** ____/____/_____