College of Nursing
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

Seasonal Influenza Vaccination Consent

2018-2019

Printed Name:_____**DOB**_____

Address:_____**Phone:**_____

Consent for Influenza Vaccine

I have been given an opportunity to read the CDC Vaccine Information Statement (VIS)(Interim) and have read or had explained to me the information about the Influenza (Flu) vaccine. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the influenza (Flu) vaccine. I hereby release University of Colorado Health and its employees from any claims arising out of the taking this vaccine.

Please Circle Yes or No

1: This is the first time I have ever had a flu vaccine *Advised to wait 15 minutes before leaving our area to be observed for a possible reaction* **Yes or No**

2: Documented severe allergic reaction to eggs or egg products or other components of the flu vaccine. *If yes, consult with your physician.* **Yes or No**

3:Have you ever had a history of Guillan-Barre Syndrome (GBS) within 6 weeks of receiving influenza vaccine? *If yes, consult with your physician.* **Yes or No**

4: Have you had any of the following: a serious illness, fever, a bleeding disorder, a serious reaction to a previous flu shot, taking anticoagulants, a latex allergy, or immunocompromised disorder? *If yes, consult with your physician.* **Yes or No**

5: Have you had a bone marrow transplant within the past six months? **Yes or No**

Signature:_____ **Date:**_____

FOR OFFICE USE:

Route: IM X Site: Right____ Left____

Fluzone (Sanofi Pasteur) Lot# _____ Exp Date: _____

Afluria (Sequris) Lot# _____Exp Date: _____

Date of VIS: _____

Vaccine Administered By:_____Date:_____Time:_____