

## Inactivated Influenza Vaccine Consent & Administration (≥ 18 years of age)

Name (Print) \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone No. \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

 Employer Commonwealth of Kentucky Employee ID # (as applicable) \_\_\_\_\_

 Insurance plan/payor (if known) N/A

**Complete the following if you are an employee's dependent authorized to receive care in the Premise Health facility.**

 Dependent Relationship to employee/subscriber:  Spouse  Child  Other \_\_\_\_\_

The influenza vaccine is prepared using a combination of strains of both the influenza A and influenza B viruses based upon the recommendations of the Centers for Disease Control and Prevention (CDC) and the Advisory Council on Immunization Practices (ACIP). This vaccine is prepared using an inactivated/killed form of the flu virus and it is therefore impossible for the vaccine to cause the flu. Possible side effects of the vaccine are included on the Vaccine Information Statement.

**Please answer the following questions:**

- Have you ever received the influenza vaccine?  Yes  No
- Are you now, or could you possibly be, pregnant?  Yes  No  N/A
- Are you allergic to any medications, thimerosal, eggs or egg products?  Yes  No
- Have you ever had an allergic reaction to the flu vaccine or other vaccine?  Yes  No
- Are you currently sick or have a fever?  Yes  No
- Have you ever had Guillain-Barré Syndrome or other neurological (nervous system) disorder?  Yes  No

I have read the provided influenza Vaccine Information Statement and have had any questions answered to my satisfaction. I believe that I understand the benefits and risks of the influenza vaccine and request that the vaccine be administered to me. I acknowledge that no guarantees or assurances have been made to me concerning the results of administration of the vaccine. I release Commonwealth of Kentucky, and Premise Health and its employees from any liability for any adverse reaction to the vaccine.

I acknowledge that I have been given the opportunity to receive the Premise Health Notice of Privacy Practices ("Notice") regarding uses and disclosures of information regarding me and my health ("Health Information"), and a copy of this Notice can be provided to me.

Recipient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**NOTE: If you have never received a flu vaccine, it is recommended that you wait in the clinic/administration area for 15 minutes after receiving the injection. If this is your first flu vaccine, and you choose not to wait, please initial on the following line.**

 \_\_\_\_\_  
 Initials

Brand Name	Afluria
Manufacturer	Seqirus
Lot Number	P100365583
Expiration Date	<u>06 / 30 / 2022</u>

Dose	0.5 ml	
Injection Site	Deltoid	
	<input type="checkbox"/> Right	<input type="checkbox"/> Left

 VIS, dated 8/6/21, provided and vaccine administered on \_\_\_\_/\_\_\_\_/\_\_\_\_, at \_\_\_\_:\_\_\_\_ a.m. / p.m. by:

 \_\_\_\_\_  
 Staff Member Printed Name

 \_\_\_\_\_  
 Staff Member Signature