ASPIRUS HEALTH

Influenza Consent 2022-2023

COMPANY:

PRINT Name: Last, First, Middle Initial _____ **DOB:** _____

Address:_____**City:**_____**State:**_____ **Zip Code:** _____

Phone #:_____**SS#: XXX-XX-**_____**Mother's Maiden Name:**_____

If you have had recent chemotherapy, radiation therapy, or steroids (except inhaled), these conditions may decrease the effectiveness of the vaccine. However, flu vaccination is still encouraged. Flu vaccination is recommended for any woman who will be breastfeeding during the influenza season or will be pregnant during the influenza season. Vaccination is recommended for anytime trimester.

To allow medical care provider(s) accurate immunization status information or immunization assessment, information will be sent to the Wisconsin Immunization Registry. Individuals have the right to request that their medical care provider not forward immunization information to the Registry. Social Security number and mother's maiden name are used as validiation information for WIR data entry.

Screening Questions

If you answer "Yes" you may still be able to be vaccinated, however, additional questions will be asked.	*Circle Answer*	*Comments/Notes*
1) Is this the first time you have received the influenza vaccine? *I understand that I will be required to remain in this area for 15 minutes following vaccination for monitoring.*	**No Yes**	
2) Have you had a serious reaction to the influenza vaccine in the past?	**No Yes**	
3) Are you feeling sick today (more than a mild illness) or do you have a fever?	**No Yes**	
4) Do you have an allergy to medications, food, eggs or a component of the vaccine or packaging - gelatin, thimerosal, latex, etc?	**No Yes**	
5) Have you received any immunizations with in the last 28 days?	**No Yes**	
6) Have you been diagnosed with Guillain-Barre Syndrome after receiving prior influenza vaccinations?	**No Yes**	
7) Do you have a bleeding disorder? **If YES, and experienced recent uncontrollable bleeding, you will be referred to your provider for your vaccine.**	**No Yes**	
8) Do you take an anticoagulant, "Blood Thinner" medication? **If YES, and recent labs on Coumadin are out of safe range, you will be referred to your provider for your vaccine.**	**No Yes**	
9) Are you under the age of 18? **If under the age of 18 a parent or guardian signature is required.**	**No Yes**	***Signature of parent or guardian:***

CONSENT:

I have read and understand the VIS – Vaccine Information Statement. I had the opportunity to ask questions that were answered to my satisfaction.
I understand the benefits and risks to the vaccine and request that the vaccine be given to me.
I understand this authorization does not contain an expiration date; however, I may revoke it with written notice.
I understand this authorization allows my vaccine record to be shared with my employer.

Patient Signature_____ **Date**_____

☐ Employee **OR**
☐ Spouse (Employee Name) _____

Vaccine Administration Record – Completed by Administrator

Vaccine	Date Given	Manufacturer Vaccine Name Lot # Exp Date	Dose Route Body Site	Administrator *Initial - Name & Title*	WIR Entry *Initials*
Influenza **VIS Publish Date** 8-15-2019 - *English*	**DATE:** _____ **TIME:** _____	**Manufacturer: GSK** **Vaccine Name: Flulaval Quad** **Lot #:** __ _____ **Expires:** __6/30/2023_____	Dose: **0.5 ml** Route: **IM** ---------- **Injection Site:** *(circle one)* Left Deltoid Right Deltoid	**Signature below indicates the VIS was given to the patient and vaccine administered by:** _____ ***Staff Signature*** _____ ***Title***	**Date Entered into WIR** _____ *Staff Initials* _____

OH-100 100417